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ABSTRACT

The final report of the Regional Intervention Program (RIP) for Preschoolers and Parents, Expansion Project, describes activities of the project's third year. The project provided direct services to 363 handicapped children (aged 0 through 8 years) as well as preservice and inservice training to almost 10,000 regular or special educators. Major sections deal with each of the three program components (community awareness and early identification, RIP replication, and RIP related field based training) in terms of development, implementation, and evaluation. Also included is the text of a study titled, "Long Term Effects of Oppositional Child Treatment with Mothers as Therapists and Therapist Trainers" by P. Strain, a followup study of 40 behaviorally disordered children who were clients of the RIP program as preschoolers. Among conclusions of the study were that Ss' social interactions in the home were positive and their nonsocial behavior appropriate, and that there were no differences in teachers' rating of Ss' behavior and class peers. The appendix includes various program materials including brochures, contracts, parental consent forms, questionnaires, and inservice program schedules. (DB)

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# The Regional Intervention Program
# Expansion Project

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## FINAL REPORT

Presented to The Office of Special Education
Handicapped Children's Early Education Program
(Outreach)

September 21, 1981

by The RIP Advisory Committee, Inc.
Nashville, Tennessee

EC 142477

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# INTRODUCTION

## The Regional Intervention Program

The Regional Intervention Program for Preschoolers and Parents, more commonly referred to as RIP, began in September 1969, at the John F. Kennedy Center for Research on Human Development and Education, George Peabody College for Teachers, Nashville, Tennessee. Original funding was provided by the Bureau of Education for the Handicapped, Handicapped Children's Early Education Program, U.S. Office of Education, Department of Health, Education, and Welfare. Since June, 1972, RIP has been operated by the Tennessee Department of Mental Health and Mental Retardation through Middle Tennessee Health Institute.

RIP serves families of handicapped preschool children under five years of age. The 518 children served since 1969 have been characterized by a wide variety of presenting problems, ranging from mild behavior disorders to severe developmental delays. There is no charge to families for RIP services. Instead, one parent or other primary caregiver agrees to participate five mornings or three afternoons per week in the program, working with the target child and with other families during the active treatment period. In addition, the adult agrees to provide services and training for a minimum of 78 treatment days (usually about six calendar months) to new families after work with the target child is completed. RIP has no waiting list, so families can begin the treatment program as soon as it is convenient for them. The average length of stay for a child in active treatment is eight months.

RIP is organized on a modular basis. Each direct service module is coordinated by a trained parent who provides systematic training for each new family entering the program. Four masters level professionals called Resource Staff, serve as middle managers of the overall RIP system. Responsibility for objectives, operations, and outputs of all RIP modules rests with Resource staff members. The modules include: Referral and Intake, Administration, Program Operations Data, Preschool Classrooms, Individual Tutoring, Generalization Training, Media, Theory Training, Liaison, and Visitation. The entire RIP system is governed by a management-by-objectives approach at the modular and individual family levels. A network of professional consultants are available to the Resource Staff.

A nine member Evaluation Committee, composed of five former RIP parents and four community members, monitors treatment and program administration activities on a management-by-objectives basis during its monthly meetings. The Evaluation Committee serves as the point of direct interface between RIP and the Tennessee Department of Mental Health and Mental Retardation.

A more extensive description of RIP, including evidence of the national and international recognition accorded the program since its inception, is contained in the application for HCEEP Outreach funding (The Regional Intervention Program Advisory Committee, Inc., Note 1.)

## RIP Expansion Project

The RIP Expansion Project (formerly called the Early Intervention Expansion Project) was organized to enable systematic replication of the RIP model for service delivery to young handicapped children. Replication was sanctioned by the state government on February 28, 1974 when the Tennessee General Assembly passed House Resolution 109 requesting that the Commissioner of Mental Health and Mental Retardation prepare a plan for statewide expansion of the Regional Intervention Program. The completed plan was submitted to the speaker of the House of Representatives December 20, 1974.

Initial funding for replication training and stimulation of new sites was provided by the RIP Advisory Committee, Inc., beginning September 2, 1974. (The committee is a private nonprofit corporation whose board of directors is composed of representatives from the Tennessee Department of Mental Health and Mental Retardation, the Junior League of Nashville, and the John F. Kennedy Center for Research on Human Development and Education, George Peabody College for Teachers of Vanderbilt University.) On June 1, 1976, major administrative and fiscal responsibility for the Project was transferred to the Office of Children and Youth Services, Middle Tennessee Mental Health Institute, Tennessee Department of Mental Health and Mental Retardation. The RIP Advisory Committee continued to establish major policy guidelines for the RIP Expansion Project, to monitor its ongoing activities, to serve as a board of certification for official Expansion Projects, and to provide limited funds for replication training and special expenditures. During the September 2, 1974, through December 31, 1977 period, the RIP Expansion Project conducted five major training cycles and four special training cycles involving a total of 27 trainees. As of January 1, 1978, nine certified RIP Expansion sites were in operation. Further information about the Expansion Project is found in the Component B section of this report.

## Summary of Activities Supported by Grant #G007803105

RIP Expansion Project activities supported by Outreach Grant #G007803105 were organized into five components: (a) Administration, (b) Component A--Community Awareness and Early Identification; (c) Component B--RIP Replication; (d) Component C--RIP Related Field Based Training and (e) Longitudinal Follow-up Study. A detailed explanation of the need for these activities is found in the application for HCEEP outreach funding (Regional Intervention Program Advisory Committee, Inc., Note 1). A brief description of components and a summary of achievements at the end of the three year funding period are given below. Detailed descriptions of activities per component are found in the major report sections that follow. Additional information concerning project activities is found in documents previously submitted to HCEEP (The Regional Intervention Program Advisory Committee, Inc., Note 2; The RIP Advisory Committee, Inc., Note 3).

## Component A Summary

Component A addressed the need to stimulate parental awareness regarding early identification and treatment of young handicapped children. Project Year One activities centered around an assessment of 179 rural parents' knowledge and attitudes about these topics. Results of the survey were presented to the Fourth National Institute on Social Work (Kurtz & Devaney, Note 4). They will be published in the Child Care Quarterly journal (Kurtz, Devaney, Strain, & Sandler, in press). A discussion of the implications of the assessment was published in the Journal of the Tennessee Medical Association (Devaney & Rule, 1981).

Second year Component A activities included the production and rural field testing of educational materials designed to stimulate community awareness of child development and the need for early intervention. The materials included CHILD CHECK, a slide tape show (also available in film), the CHILD CHECK DIARY designed to assist parents in checking their children's development and the CHILD CHECK Manual which describes how to use the materials for child find activities. LINC Resources, Inc. obtained copyright for these materials in 1981 and they are distributed by Lawren Productions, Inc., Mendocino, California (see brochure in Appendix). A manuscript reporting the field test results has been submitted for publication (Kurtz, Devaney, Strain, & Sandler, Note 5). The results have been presented at one national professional conference (Devaney & Kurtz, Note 6) and are scheduled to be presented at another (Kurtz, Note 7). Descriptions of the Child Check activities have also been presented at seven state and regional conferences (Devaney, Notes 8, 9, 10; Devaney & Herbers, Note 11; Devaney, Rule, & Nason, Note 12; Kurtz, Note 13; Kurtz & Baringer, Note 14).

Third year activities included field testing the Child Check materials in an urban setting and in statewide school system child find efforts. These activities are described in the Component A section later in this report. Two additional manuscripts reporting urban test findings are expected to be submitted for publication.

## Component B Summary

Component B addressed the need for further development of the RIP replication process. Component B replication activities employed the tripartite organizational model established in 1974. The model includes:

(a) careful selection of sponsoring agencies and individual trainees, with all administrative and fiscal relationships clearly specified prior to project site approval by the RIP Advisory Committee, Inc.; (b) competency-based training, generally eight to 10 weeks in duration at the RIP Nashville facility; and (c) ongoing training and consultation by RIP Expansion staff following trainees' return to their local communities.

Component B activities were designed to further disseminate the RIP model, to improve existing training materials and to systematically examine the replication process. At the end of the three year funding period there were five model sites in Tennessee, four out-of-state, two awaiting certification and one in the process of serious negotiation about replication. Two Expansion Staff positions continue to receive state financial support. Twenty-seven persons participated in replication training between January 1, 1978, and June 30, 1981. Seven new objectives incorporating Component C videotape and/or printed materials were added to the training program and a series of parent training materials for use in RIP sites was produced in conjunction with Component C. The systematic examination of the replication project was completed (Innes, 1981) and is expected to be published at a later date. A summary is found in the Component B "Implementation and Evaluation" section of this report.

During the three year funding period six publications about the RIP model were printed or in press (Special report: 30 years of achievement awards: A review, 1978; The Regional Intervention Program, 1979; Eller, Jordan, Parish, & Elder, 1979; Parrish & Hester, 1980; Strain, Young &

Horowitz, 1981; Timm & Rule, in press). Four presentations about RIP or The RIP Expansion Project were made at professional conferences (Rule, Baringer, Brown, Cohen, Hallworth, & Welch, Note 15; Timm, Notes 16, 17; Kerkeles & Timm, Note 18).

## Component C Summary

Component C addressed the need for personnel in a variety of public and private agencies to be trained to serve handicapped children. A Trainer's Manual, two training programs, Using Skills Effectively and Using Resources Effectively, and three series of training videotapes with a total running time of 194 minutes were produced. The materials were field tested with 321 participants from a variety of agencies. The participants included professionals, paraprofessionals and students in both inservice and preservice settings. The materials have been submitted to LINC Services, Inc. for review for national dissemination. Two reports of field test results were submitted for publication (Fiechtl, Rule, Harrison, & Bourgeois, Note 19; Rule, Fiechtl, Bourgeois, & Harrison, Note 20). Results of training were presented to the Council for Exceptional Children Conference (Fiechtl, Rule, & Harrison, Note 21) and to two state conferences (Bourgeois, Fiechtl, & Rule, Note 22; Harrison, Rule, & Fiechtl, Note 23).

## Longitudinal Follow-up Summary

The longitudinal follow-up of 40 oppositional children treated at the Regional Intervention Program was supported by a supplement to Grant #G007803105 approved in March 1980. Results of the study are in press (Strain, Steele, Ellis, & Timm) and were presented to two national professional conferences (Strain & Rule, Note 24; Strain, Steele, & Ellis, Note 25).

## PROJECT YEAR THREE: SUMMARY DATA

Summary information about numbers of children served in Project Year Three, July 1, 1980, through June 30, 1981, by RIP Expansion Project sites is presented in Table 1, Part A on the following page. Table 1, Part B describes staffing of the projects. Table 2 summarizes various training activities conducted during Year Three.

## ADMINISTRATION COMPONENT

### Staff

RIP Expansion Project Year Three staff members are listed below.

| | |
|---|---|
| Project director | Matthew A. Timm, Ph.D. |
| Project evaluator | Phillip S. Strain, Ph.D. |
| Administrative assistant | Mary F. Lane |
| Component A director | Barbara Devaney, M.S.W. |
| Component A field coordinator | P. David Kurtz, Ph.D. |
| Component B director and Project coordinator | Sarah Rule, Ph.D. |
| Projects consultant | Linnea Harrison, M.S. |
| Component C director | Barbara Fiechtl, M.S. |
| Component C field coordinator | Michelle Bourgeois, M.S. |
| Research assistant | Peggy Steele |
| Research consultant | Toni Ellis, M.S. |

### Contractual Agreements

Contracts for specific services associated with Grant #G007803105 were negotiated for each project year between the RIP Advisory Committee, Inc. and the State of Tennessee Department of Mental Health and Mental Retardation through Middle Tennessee Mental Health Institute. The contracts included purchase of personnel time (Timm, Strain, & Ellis), rental of office space and communications services (telephone and duplication).

Contracts for specific media production services were negotiated between the RIP Advisory Committee, Inc. and three Nashville, Tennessee

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF EDUCATION

EDUCATION FOR THE HANDICAPPED

## APPLICATION FOR FEDERAL ASSISTANCE (Nonconstruction Programs)
## SUPPLEMENTARY QUESTIONNAIRE

| | |
|---|---|
| 1. APPLICANT NAME (from Item 4 on SF 424)<br>RIP Advisory Committee, Inc. | 2. DESCRIPTIVE TITLE OF PROJECT (from Item 7 on SF 424)<br>The RIP Expansion Project |

### INSTRUCTIONS

Programs may involve Demonstration/Service activities and/or Preservice or Inservice Training activities. Any applicant whose project calls for such activities must fill out the relevant portions of the tables below. Data presented should be for the year of funding requested and will be used as one base measure to determine accomplishment for Demonstration/Service and/or Preservice or Inservice Training activities (see Part IV, Item 3b in the Instructions for the application).

In Table 1 enter the projected performance data for the first budget period into the appropriate boxes. Use age as of the start of the grant project. Data for lines 1 through 11 are for those enrolled or receiving major services and not merely screened, referred, or given minimal or occasional services.

Table 2: Preservice/Inservice Training Activities. Persons can receive training in two or more areas of concentration. While it is acceptable to have duplicate counts of trainees across areas of concentration (rows 1-12), the TOTAL (row 13) should represent an unduplicated count of persons to receive training.

TABLE 1
PART A - DEMONSTRATION/SERVICE ACTIVITIES

| | TYPE OF HANDICAP | NUMBER OF HANDICAPPED PERSONS TO BE SERVED BY AGE | | | |
|---|---|---|---|---|---|
| | | AGES 0-2 | AGES 3-5 | AGES 6-8 | AGES 9-21 |
| 1. | MENTALLY RETARDED | 16 | 18 | 2 | - |
| 2. | HARD OF HEARING | - | - | - | - |
| 3. | DEAF | - | - | - | - |
| 4. | SPEECH IMPAIRED | 4 | 8 | - | - |
| 5. | VISUALLY HANDICAPPED | 1 | - | - | - |
| 6. | SERIOUSLY EMOTIONALLY DISTURBED | 68 | 164 | 20 | - |
| 7. | ORTHOPEDICALLY IMPAIRED | 1 | - | - | - |
| 8. | OTHER HEALTH IMPAIRED | 3 | - | - | - |
| 9. | SPECIFIC LEARNING DISABILITIES | - | - | 1 | - |
| 10. | DEAF-BLIND | - | - | - | - |
| 11. | MULTIHANDICAPPED | 13 | 42 | 2 | - |
| 12. | TOTAL | 106 | 232 | 25 | - |

OE FORM 9037, 3/79

### TABLE I
### PART B – PROJECT STAFF TO PROVIDE SERVICES TO RECIPIENTS IN TABLE IA

| TYPE OF STAFF | NUMBER | |
|---|---|---|
| | FULL TIME | PART TIME *<br>(As full time equivalents) |
| PROFESSIONAL PERSONNEL (excluding teachers) | 17 | 1.5 |
| TEACHERS ** | – | – |
| PARAPROFESSIONAL | 0 | 6.5 |

### TABLE I
### Part C – ANCILLARY SERVICES TO PERS WITH SPECIAL NEEDS
### (Including Recepients in Table IA

| SERVICE | NUMBER OF HANDICAPPED |
|---|---|
| SCREENED | |
| DIAGNOSTIC AND EVALUATIVE | |
| OTHER RESOURCE ASSISTANCE (specify) | |

*Amount of time for less than full-time work divided by time normally required in a corresponding full-time activity.

**Staff members who instruct pupils.

### TABLE 2 - PRESERVICE/INSERVICE TRAINING ACTIVITIES

| | AREA OF CONCENTRATION | NUMBER OF STUDENTS TO RECEIVE PRESERVICE TRAINING BY DEGREE PROGRAMS* | | | | NUMBER OF PERSONS TO RECEIVE INSERVICE TRAININ | |
|---|---|---|---|---|---|---|---|
| | | A.A. | B.A. | M.A. | POST-MASTERS | REGULAR EDUCATORS | SPECIAL EDUCATO |
| 1. | ADMINISTRATION | | | | | | |
| 2. | EARLY CHILDHOOD non-categorical | 98 | 25 | 11 | 3 | 8,548[a] | 344[b] |
| 3. | MENTALLY RETARDED | | | | | | |
| 4. | SPECIFIC LEARNING DISABILITIES | | | | | | |
| 5. | DEAF BLIND | | | | | | |
| 6. | DEAF / HARD OF HEARING | | | | | | |
| 7. | VISUALLY HANDICAPPED | | | | | | |
| 8. | SERIOUSLY EMOTIONALLY DISTURBED | | | | | | |
| 9. | SPEECH IMPAIRED | | | | | | |
| 10. | ORTHOPEDICALLY IMPAIRED | | | | | | |
| 11. | OTHER HEALTH IMPAIRED | | | | | | |
| 12. | MULTIHANDICAPPED | | | | | | |
| 13. | TOTAL (Unduplicated Count) | 98 | 25 | 11 | 3 | 8,548 | 344 |

*Formalized arrangements with institutions of higher education or faculty

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[a] Includes 59 persons trained to teach young handicapped children and 8489 persons trained in early identification of handicapping conditions

[b] Includes parents trained in early intervention techniques with their own young handicapped children

companies. Details about these agreements were provided in Project Year One and Year Two Performance Reports (The Regional Intervention Program Advisory Committee, Inc., Note 2. The RIP Advisory Committee, Inc., Note 3). A copy of the media production services contract negotiated for Year Three is found in the Appendix of this report.

## Accounting and Tax Preparation

Tax preparation and consultation about accounting services was provided by Frasier and Dean, CPAs, 3813 Cleghorn Avenue, Nashville, Tennessee. Charges were determined on a per hour basis.

## Advisory Council

The working relationship between Project staff and Advisory Council members (see Appendix for list) was maintained both through meetings and direct contact with individual council members as necessary.

## REFERENCE NOTES

1. The Regional Intervention Program Advisory Committee, Inc. The RIP Expansion Project, Nashville, Tennessee. Submitted to the Bureau of Education for the Handicapped, February 24, 1978.
2. The Regional Intervention Program Advisory Committee, Inc. Performance Report: Project Year One, Nashville, Tennessee. Presented to Handicapped Children's Early Education Program (Outreach), Bureau of Education for the Handicapped, September 25, 1979.
3. The RIP Advisory Committee, Inc. Performance Report: Project Year Two, Nashville, Tennessee. Presented to the Office of Special Education and Rehabilitative Services, Handicapped Children's Early Education Program (Outreach), September 22, 1980.
4. Kurtz, P. D., & Devaney, B. Early awareness of handicapped preschoolers or finding a needle in a haystack. Paper presented at the Fourth National Institute on Social Work in Rural Areas, Laramie, Wyoming, July 1979.
5. Kurtz, P. D., Devaney, B., Strain, R., & Sandler, H. Effects of mass media and group instruction on increasing parental awareness of early identification. Manuscript submitted for publication, 1981.
6. Devaney, B., & Kurtz, P. D. Effectiveness of mass media campaigns and direct instruction on stimulating community awareness of early identification of handicapped children. Poster presented at the meeting of American Association on Mental Deficiency, Detroit, May 1981.

7. Kurtz, P. D. Community organization approaches to early detection of handicapped children. Paper to be presented to Conference of the National Association of Social Workers, Philadelphia, October 1981.

8. Devaney, B. Child Check: An early intervention model. Paper presented to the Tennessee Association of Mental Health Centers, October 1980.

9. Devaney, B. Child Check. Paper presented to the Conference of the Tennessee Association for Retarded Citizens, April 1981.

10. Devaney, B. Child find. Paper presented at the Conference of Educational Advocacy for Children with Handicaps (EACH), Nashville, May 1981.

11. Devaney, B., & Herbers, S. Child Check: How to design a preventative mental health program for parents. Paper presented to the Southeast Regional Conference of the American Association of Psychiatric Services for Children, Nashville, April 1980.

12. Devaney, B., Rule, S., & Nason, H. Child find/screening. Paper presented to the Conference on Inservice Education Programs for Preschool Handicapped Children, Chapel Hill, Tennessee, June 1980.

13. Kurtz, P. D. Child Check--Awareness for parents of young children. Paper presented to the Tennessee Early Childhood Education Conference, Nashville, August 1980.

14. Kurtz, P. D., & Baringer, C. Child find activities of the RIP Expansion Project. Paper presented to the Tennessee Conference on Social Welfare, Martin, Tennessee, October 1979.

15. Rule, S., Baringer, C., Brown, L., Cohen, C., Hallworth, P., & Welch, L. The RIP Expansion Project: Parent implemented intervention for handicapped children. Poster presented at the Conference of the Tennessee Behavior Therapy Association, Nashville, February 1980.

16. Timm, M. A. RIP: A therapeutic system for preschoolers and parents. Presentation to the 4th Annual Convention of the Midwestern Association for Behavior Analysis, Chicago, May 1978.

17. Timm, M. A. Regional Intervention Program: A model mental health program for families with disturbed preschoolers. Presentation to the 30th Annual Obstetric-Pediatric Seminar, DHEW Region IV, Nashville, Tennessee, August 1980.

18. Kerkeles, B., & Timm, M. A. Parent involvement models. Presentation to the 1978 Project Director's Conference, Handicapped Children's Early Education Program, Bureau of Education for the Handicapped, Washington, D.C., November 1978.

19. Fiechtl, B., Rule, S., Harrison, L., & Bourgeois, M. Training over time: A field-based model for inservice delivery. Manuscript submitted for publication, 1981.

20. Rule, S., Fiechtl, B., Bourgeois, M., & Harrison, L. The need to disseminate evaluations of data-based training programs. Manuscript submitted for publication, 1981.

21. Fiechtl, B., Rule, S., & Harrison, L. Training over time: Practicing what is preached. Paper presented at the Conference of the Council for Exceptional Children, New York, April 1981.

22. Bourgeois, M., Fiechtl, B., & Rule, S. *RIP field-based training: A case for applied training with high school students*. Poster presented at the Conference of the Tennessee Behavior Therapy Association, Nashville, April 1981.

23. Harrison, L., Rule, S., & Fiechtl, B. *Using skills effectively and using resources effectively: RIP-related field-based training*. Poster presented at the Tennessee Behavior Therapy Association Conference, Nashville, February 1980.

24. Strain, P. S., & Rule, S. *Prevention of childhood behavioral disorders: Longitudinal effects of preschool intervention with mothers as therapists*. Paper presented at the CEC Topical Conference on the Seriously Emotionally Disturbed, Minneapolis, August 1980.

25. Strain, P. S., Steele, P. C., & Ellis, T. P. *Prevention of children's behavior disorders: Longitudinal effects of preschool intervention with mothers as therapists*. Presentation to the 3rd annual First Step-Preschool Handicapped Institute, Myrtle Beach, South Carolina, March 1981.

## REFERENCES

Devaney, B., & Rule, S. Child Check: A cooperative program to stimulate early identification of handicapped children. Journal of the Tennessee Medical Association, 1981, 74, 363-364.

Eller, P., Jordan, H., Parish, A., & Elder, P. Professional qualification: Mother. In R. L. York & E. Edgar (Eds.), Teaching the severely handicapped: Vol. IV. Seattle: American Association for the Education of the Severely/Profoundly Handicapped, 1979.

Innes, S. M. An analytic description of the replication process of an early intervention program: A case study. Unpublished doctoral dissertation, George Peabody College for Teachers of Vanderbilt University, 1981.

Kurtz, P. D., Devaney, B., Strain, P., & Sandler, H. Rural parents' attitudes and knowledge regarding handicapped children: Implications for developing an early identification program. Child Care Quarterly, in press.

Parrish, V., & Hester, P. Controlling behavior techniques in an early intervention program. Community Mental Health Journal, 1980, 16(2), 169-175.

Special report: 30 years of achievement awards: a review. Hospital and Community Psychiatry, 1978, 29, 659-670. Available from Regional Intervention Program.

Strain, P. S., Steele, P. C., Ellis, T. P., & Timm, M. A. Long term effects of oppositional child treatment with mothers as therapists and therapist trainers. Journal of Applied Behavior Analysis, in press.

Strain, P. S., Young, C., & Horowitz, J. An examination of child and family demographic variables related to generalized behavior changes during oppositional child training. Behavior Modification, 1981, 5, 15-26.

The Regional Intervention Program. In Mental retardation: The leading role. 1978 Report, President's Committee on Mental Retardation. U.S. Government Printing Office, DHEW, Publication No. (OHDS) 79-21018, 1979.

Timm, M. A., & Rule, S. RIP: A cost effective parent-implemented program for young handicapped children. Early Child Development and Care. London, England: in press.

# COMPONENT A

# COMMUNITY AWARENESS AND EARLY IDENTIFICATION

## DEVELOPMENT

Needs assessments were conducted in one urban and three rural communities to determine parents' abilities to identify handicapping conditions and to obtain help for their own children. A set of materials used in two distinct community awareness programs (mass media and group instruction) was prepared to address parents' needs in the rural communities. A combined mass media and group instruction campaign was subsequently planned for the urban test. The following tasks were carried out to achieve these objectives.

### Rural Field Test

From a pool of nine rural communities, three were selected based on their demographic similarity and the availability of services for preschool handicapped children (see Table 1). Bolivar, Paris, and Pulaski are rural county seats with populations under 10,000. The per capita incomes in 1970 were similar. The mean years of education was 8.8 in Bolivar in 1970, compared with 10.8 and 10.1 years in Paris and Pulaski, respectively. Racial composition in Paris and Pulaski was approximately 70% white and 30% black, compared with 60% white and 40% black in Bolivar.

A total of 179 randomly selected parents was interviewed: 59 in Bolivar and 60 in both Paris and Pulaski. Table 2 presents the demographic characteristics of the surveyed parents. At least 90% of the subjects in each community were female. Mean years of education were nearly identical in the three communities. More black parents were surveyed in

## TABLE 1

## TARGET COMMUNITY DEMOGRAPHIC CHARACTERISTICS

| Characteristics | Communities<br>Bolivar | <br>Paris | <br>Pulaski |
|---|---|---|---|
| Population | 6,700 | 9,900 | 7,000 |
| Per capita income | 3,018 | 4,075 | 4,464 |
| Mean education years | 8.8 | 10.8 | 10.1 |
| Race: % white | 60 | 70 | 70 |
| % black | 40 | 30 | 30 |

## TABLE 2

## DEMOGRAPHIC CHARACTERISTICS OF PARENTS

| Characteristics | Original Surveyed Group<br>Bolivar<br>n = 59 | <br>Paris<br>n = 60 | <br>Pulaski<br>n = 60 |
|---|---|---|---|
| Sex: % male | 10 | 7 | 10 |
| % female | 90 | 93 | 90 |
| Race: % black | 52 | 23 | 25 |
| % white | 48 | 77 | 75 |
| Income: % under 10,000 | 55 | 30 | 41 |
| % 10,000-19,999 | 15 | 49 | 46 |
| % 20,000 or more | 30 | 21 | 13 |
| % Family with handicapped member | 14 | 23 | 12 |
| % Married | 63 | 80 | 83 |
| Mean education (years) | 11.9 | 12.0 | 11.8 |

Bolivar than in Paris or Pulaski and the highest percentages of parents in the three communities with annual incomes under $10,000 and over $20,000 resided in Bolivar. Fewer surveyed parents were married in Bolivar than in Paris or Pulaski.

A survey was designed to measure four areas of parental knowledge (see Appendix): (a) educational rights of handicapped children, (b) community services for handicapped children, (c) the importance of early intervention, and (d) child development. The survey was pilot tested on 24 parents from various ethnic groups and socioeconomic levels.

Interviews were conducted in the homes of the target parents. The survey results from the three communities were very similar (see Table 3). Areas in which parents needed more information were almost identical. Over one-half of the parents did not know that in Tennessee handicapped children have the right to a free education at age four, and over half believed public schools are required by law to separate normal from handicapped children. Over 40% did not know public schools are required to look for and enroll handicapped children in school and that schools are responsible to find appropriate programs for handicapped children.

Parent responses to two questions regarding services for handicapped children were also comparable. When asked to whom parents should turn if they think they have a handicapped child, 73% answered doctor, 9% answered not sure, and the remainder gave a variety of responses. When asked, "What people and agencies in your community provide help or services to handicapped children?" 28% answered schools, 28% answered mental health, 14% answered human services, 8% answered public health, 6% answered doctor, 6% answered Easter Seals and 18% answered "don't know." (These percentages surpass 100 because some parents gave several responses.)

The majority of parents believed parents are often the last to notice their own children's handicaps, that the family doctor should be responsible for noticing handicaps in children, and that prayer often helps mentally retarded children become like other children. The majority did not think handicapped children should be sent to school at a younger age than other children.

Ten out of 27 developmental items were answered correctly by 2/3 of all respondents. On six items parents tended to overestimate children's abilities, particularly in language and motor skills. On the remaining 11 items, parents underestimated children's abilities. Table 3 illustrates the mean scale scores for the attitudinal, child development and legal rights items. The data were analyzed and five goals for educating

TABLE 3

MEAN SCALE SCORES-RURAL PREASSESSMENT

| | Bolivar | Paris | Pulaski | Mean Total |
|---|---|---|---|---|
| Attitudinal Scale (15 items) highest possible score = 60 | 38.1 | 40.1 | 40.0 | 39.4 |
| Developmental Scale (27 items) highest possible score = 108 | 74.1 | 80.6 | 79.5 | 78 |
| Educational Rights Scale (8 items) highest possible score = 16 | 11.9 | 11.6 | 12.2 | 11.9 |
| Total Score | 124.1 | 132.3 | 131.6 | 129.2 |

parents in awareness campaigns were formulated: (a) the parent's important role in early identification, (b) the importance of early intervention, (c) services available for handicapped children and their families, (d) handicapped children's educational rights, and (e) the need for parents to use the CHILD CHECK Diary in monitoring their children's development.

Child find awareness materials and delivery methods from seven states were examined and visits were made to Rhode Island and Connecticut Departments of Special Education. Although none of the existing materials adequately addressed the awareness priorities, the search provided some guidance regarding the design of the CHILD CHECK mass media and group instruction programs.

The group instruction materials produced for CHILD CHECK programs included a 24 minute, three-part slide tape show which addressed the five goals, a brochure about local services for young children, two posters focusing on the role of parents, and a Diary to enable parents to monitor their children's development. A brochure highlighting the legal rights of preschool handicapped children accompanied the CHILD CHECK materials. The group instruction format was designed to be given to groups of parents and to last about one hour. The presentation was to revolve around the slide-tape show accompanied by mini-lectures, discussions and handouts.

The materials developed for the mass media approach were the same as those for group instruction with the exception that the slide tape show was not to be used. The CHILD CHECK message was to be disseminated primarily in three modes: (a) display of posters and distribution of diaries and brochures in various agencies, churches, stores and public places; (b) use of community-wide communication networks such as radio, TV and newspapers; and (c) solicitation of support from key community members such as the mayor, ministers and agency directors.

Simultaneous with the above described activities, commitments were obtained from two rural school systems, Bolivar and Paris, to assist in implementing the CHILD CHECK program in their communities. Support from churches, agencies, local government and volunteer groups was also cultivated in each community. The evaluation procedure to compare the effects of mass media versus group instruction is described in Table 4.

TABLE 4

EVALUATION DESIGN AND PROCEDURES

| Community | Intervention I (8/79 - 10/79) | Intervention II (1/80 - 3/80) |
|---|---|---|
| Bolivar | mass media campaign | group instruction |
| Paris | group instruction | mass media campaign |
| Pulaski | no intervention | television only |
| pre assessment (11/78-4/79) | post assessment I (11/79-1/80) | post assessment II (4/80-5/80) |

## Urban Field Test

Nashville, Tennessee, location of the RIP Expansion Project, was chosen for the urban field test of CHILD CHECK. The population of Metropolitan Nashville Davidson County is about 455,000. The 1970 per capita income was $3,153. The median adult educational level is 12 years. The city is 80% white and 20% black.

Eighty-one randomly selected parents in a Nashville community thought to be demographically similar to the city as a whole were given home interviews almost identical to the surveys given in the rural communities. An abbreviated version of the home interview form was used to interview 154 randomly selected parents throughout Metropolitan Nashville-Davidson County by phone (see Appendix for copy of telephone instrument). Table 5 describes the demographic characteristics of these parents. The sex, income, race, and marital status breakdown of the two groups were similar. The parents interviewed at home had a higher mean education: 15.5 years compared with 14 years for the home interviewed parents.

TABLE 5

DEMOGRAPHIC CHARACTERISTICS OF NASHVILLE PARENTS

| | Original Surveyed Parents | |
|---|---|---|
| Characteristics | Telephone Survey | Home Survey |
| Sex: % male | 15 | 4 |
| % female | 85 | 94* |
| Race: % black | 10 | 7 |
| % white | 90 | 91* |
| Income: % under $10,000 | 6 | 3 |
| % $10,000-$19,999 | 45 | 25 |
| % $20,000 or more | 49 | 48* |
| % Married | 93 | 94 |
| Mean years education | 14 | 15.5 |

*Percentages do not equal 100 because this information was not available on all subjects.

The Nashville survey results indicated parents in Nashville needed more information in the same categories as the rural communities described below. The campaign goals and the CHILD CHECK materials used in the rural campaigns were also used in the urban campaign. The CHILD CHECK message was disseminated through extensive group instruction sessions, public service announcements and interviews on radio and television, newspaper articles, and direct distribution of diaries and brochures at agencies, physicians' offices, churches and day care centers.

The support of Metro public school system, the Metro Health Department, the County Day Care Licensing Department, the Junior League, the Kiwanis Club and various other organizations in Nashville was obtained for the campaign. Endorsement by the mayor, the Davidson County Pediatric Association and agency directors was solicited. Forty-five organizations consented to being listed in a brochure describing services for young children and their families in Nashville (see Appendix). A post assessment was conducted in April and May 1981.

### School System Field Test-Model Child Find Package

Plans to field test CHILD CHECK campaigns implemented by local school systems in Tennessee were coordinated through the Tennessee Department of Education's Division for Education of the Handicapped. Each of 114 school systems in Tennessee was invited to submit a proposal for participation in training and receipt of materials developed by the RIP Expansion Project to field test the CHILD CHECK materials to help the state develop an effective, statewide child find program. School systems selected for participation were provided a CHILD CHECK slide tape show, a supply of diaries, a manual on using the materials and conducting the campaign and screening, and three consultation and training workshops. Twenty-eight proposals were submitted. Twenty-four school systems were selected to begin training in the fall. The Division for Education of the Handicapped purchased 13 films, 13 slide tape shows and 20,000 diaries for use in the campaign.

## IMPLEMENTATION AND EVALUATION

### Rural Evaluation

Two means of communicating the CHILD CHECK message, group instruction and mass media, were compared in Bolivar and Paris. While the content of the two campaign approaches was very similar, the methods of conveying the content differed, as already described. From August through October 1979, a mass media campaign was conducted in Bolivar, while a group instruction campaign took place in Paris. From January through March 1980, the approaches were reversed. During this time no intervention took place in Pulaski, which served as a control community.*

A total of 179 parents were interviewed with the survey instrument as already described between November 1978 and April 1979. Between November 1979 and January 1980, 125 parents from the original sample were interviewed with the same survey instrument with some additional questions to determine their exposure to CHILD CHECK. Between April and May 1980, 110 parents who had been surveyed twice before were given post survey II.

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*Since Pulaski and Paris received the same television stations one show aimed at the Paris audience was broadcast in Pulaski.

## Methods

The group instruction sessions, as previously described, used three modes of conveying the CHILD CHECK message to parents: the slide-tape show, a lecture and a handout. In Paris five group instruction sessions were given to 210 people, including 18 of the parents in the original sample of surveyed parents. Surveyed parents received invitations by mail to four presentations and telephoned invitations to two. In Bolivar 10 group instruction sessions were given to 161 people, including 11 surveyed parents. Surveyed parents were given written and telephone invitations to six presentations.

## Media

The mass media campaign involved distribution of all materials except the slide-tape show. In Bolivar 1,500 CHILD CHECK diaries, 100 posters and 1,900 brochures on services were distributed to agencies, physicians' offices, stores, churches and day care centers. A televised public service announcement and two radio announcements on two different stations were aired. News shorts on two television stations, three television talk shows and six radio talk shows were run. The mayor declared CHILD CHECK month, churches declared CHILD CHECK Sunday and preschool service agencies conducted a forum at which they described their services.

In the Paris mass media campaign 1,500 diaries and brochures and 60 posters were distributed. Based on the assumption that interpersonal contact might encourage greater use of the materials, personnel dispensing diaries and brochures were asked to describe to each person receiving the materials how to use them. A television and radio talk show and a public service announcement repeated on four radio stations were aired. Six articles and two photographs appeared in the daily newspaper. Letters were sent to local ministers containing educational paragraphs addressing CHILD CHECK goals for publication in weekly bulletins. The mayor declared a CHILD CHECK month. Each of the 14 physicians were given diaries to distribute to parents. A preschool forum took place at which each agency described its service. A local restaurant printed three CHILD CHECK public service announcements on its placemats.

Community involvement was critical in conducting the CHILD CHECK campaigns. The support of physicians, various service agencies, schools, and civic clubs enabled wide distribution of materials and presentations. In both Paris and Bolivar task forces were formed prior to the beginning of the campaigns to act in an advisory, planning and implementing role. Contacts with city officials, television and radio stations and physicians were cultivated by these groups. For more information on the communities' involvement in CHILD CHECK see the Performance Report: Project Year Two (The RIP Advisory Committee, Inc., Note 3).

Concurrent with the Paris city campaign, the school system of the county in which Paris is located also distributed diaries and brochures and conducted a screening of 3- to 5-year-olds in each of five elementary schools. Subsequently the Paris city school system conducted a preschool screening in response to frequent parent requests, which the school system attributed to the CHILD CHECK campaign. The effects of the concurrent campaign and screenings cannot be separated from the effects of the intervention itself.

## Results

The field evaluation of the mass media and group instruction community awareness campaigns suggested group instruction was the more effective method of increasing knowledge. Group instruction increased parents' knowledge of services and legal rights, while mass media had no impact. Parents who attended group instruction received and used the diary to monitor their children's development. Only 1/3 of parents exposed to mass media received diaries, which they used about half as often as group instruction parents to monitor their children's development. Neither type of campaign increased parents' ability to recall developmental milestones.

In Bolivar seven parents were exposed to both mass media and group instruction, compared with 14 in Paris. In Bolivar 16 parents were exposed to mass media only, compared with 15 in Paris. Three parents in Paris and four in Bolivar received group instruction only.

On the preassessment there was no difference among the three communities on their knowledge of the eight questions on the legal rights scale. At postassessment I the Paris group which had received group instruction showed significantly greater knowledge ($p \leq .01$) on the scale than Bolivar parents exposed to mass media or nonexposed parents in Paris and Pulaski. There was no significant difference on legal rights knowledge between the Paris and the Pulaksi nonexposed parents and the Bolivar parents exposed to mass media. At postassessment II there was no difference between the groups in Paris and Bolivar which had been exposed to both group instruction and mass media. There was a significant difference at the .01 level between the Paris group instruction plus mass media group and the Pulaksi nonexposed group, and a significant difference at the .05 level between the Bolivar mass media plus group instruction group and the Pulaski nonexposed group. See Table 6 for a comparison of the legal rights scale means of all of these groups at the three assessment points.

Prior to instruction six key services were identified by instruction plus mass media parents ($n = 21$) in Paris and Bolivar when they were asked: "If parents discover they have a handicapped child, whom do you think they should turn to for help?" On postassessment II the same group identified 25 services. This compares with the mass media only group ($n = 31$) which identified 10 key services on the preassessment and nine on postassessment II, and the nonexposed group which identified none on the preassessment versus four on postassessment II. In response to the question, "What people or agencies in your community provide help or services to handicapped children?" prior to instruction the instruction plus mass media group identified 30 key services compared with 25 at postassessment II; the mass media only group identified 25 on the preassessment and 30 on postassessment II; and the nonexposed group in Bolivar identified eight on the preassessment and nine of postassessment II.

There were no differences on the attitudinal scale, consisting of 15 items, between the preassessment, postassessment I or postassessment II within and across the communities and subgroups. The Paris instruction plus mass media group showed a significant gain ($p \leq .05$) on two items from pre- to postassessments conducted on-site at the group instruction, but these gains were not maintained at the subsequent postassessments I and II.

## TABLE 6

## CROSS COMMUNITY COMPARISON ON KNOWLEDGE OF LEGAL RIGHTS SCALE

All correct = 16 All incorrect = 8

| | Community A vs. Community B<br>N = 14 N = 7 | Community A vs. Community C<br>N = 14 N = 39 | Community B vs. Community C<br>N = 7 N = 39 |
|---|---|---|---|
| Pre assessment Mean | 13.29 vs. 13.86<br>N.S. | 13.29 vs. 13.28<br>N.S. | 13.86 vs. 13.28<br>N.S. |
| Intervention and Postassessment I Mean | Group Instruction vs. Mass Media<br>15.43 13.29<br>$p \le .01$ | Group Instruction v Not Exposed<br>15.43 13.05<br>$p \le .01$ | Mass Media vs. Non exposed<br>13.29 13.05<br>N.S. |
| Intervention and Postassessment II Mean | Group Instruction + Mass Media vs. Mass Media Group Instruction<br>15.43 14.29<br>N.S. | Group Instruction + Mass Media vs Not Exposed<br>15.43 12.90<br>$p \le .01$ | Mass Media + Group Instruction vs. Not Exposed<br>14.29 12.90<br>$p \le .05$ |

There were no differences within or across groups in their knowledge of developmental milestones. The diary was designed as a reference for parents to check their children's development. All 21 parents who attended group instruction received diaries and checked their children's development at least once with the diary. Eighteen checked twice or more. Of the 31 parents exposed to mass media, only 11 received diaries. Of these, three parents did not check the children's development at all, four checked once and four checked two or more times.

Recruiting surveyed parents to attend group instruction was often difficult. Meetings sponsored by existing organizations with regular meeting times were better attended than public meetings. Only seven of the 23 parents exposed to mass media in Bolivar later attended group instruction. Of the 17 parents in Paris who attended instruction, 14 heard of CHILD CHECK again in the mass media campaign. This exposure did not heighten knowledge of laws and services, but may have maintained the changes attributable to group instruction.

Channels of communication among agencies and schools were reported by agency representatives to have improved as a result of the campaigns. In Paris eight preschool children began receiving services for identified handicaps following the screening, which will be repeated annually.

## Nashville Campaign

An urban test of the CHILD CHECK campaign was conducted in Nashville from September 1980 through April 1981. In June and July 1980, a total of 80 parents in a section of Nashville reported to be demographically similar to the city as a whole were interviewed at home with the same assessment instrument used in the rural campaigns. An additional 154 randomly selected parents of Nashville children aged 0-4 were interviewed by telephone with an abbreviated version of the home survey (see Appendix) during the same month. Follow-up interviews took place with 63 of the home surveyed and 107 of the telephone surveyed parents in April and May 1981.

A combined mass media and group instruction campaign took place. A total of 119 group presentations were given to 4,133 people by 50 volunteers and staff. Those who attended group presentations saw the CHILD CHECK presentation and received a CHILD CHECK diary, a brochure developed by RIP called "Services for Young Children and their Families in Nashville" (see Appendix) and a brochure published by the state Division for Education of the Handicapped on the educational rights of handicapped children (see Appendix).

Diaries and brochures were distributed through mental health centers, public health clinics, day care centers, physicians' offices, a diaper service, hospitals, elementary schools and Crippled Children's Service. Radio and television public service announcements and restaurant placemats publicized the CHILD CHECK program, the availability of free diaries through RIP and the public school's responsibilities in serving young handicapped children. RIP staff and volunteers appeared on radio and television talk shows focusing on the CHILD CHECK campaign. Three newspapers ran two articles each on various facets of the campaign. Table 7 describes the dissemination of CHILD CHECK materials and group presentations in the Nashville campaign. A total of 833 diaries were distributed

TABLE 7

## DISSEMINATION OF CHILD CHECK MATERIALS IN NASHVILLE

| | | Group Presentations | | Diaries and brochures only distributed | | Diaries only distributed | |
|---|---|---|---|---|---|---|---|
| | | # organizations receiving presentation | # in attendance | # organizations | # of each distributed | # organizations | # diaries distribute |
| Churches | | 11 | 307 | | | | |
| Civic Groups | | 3 | 211 | 1 | 40 | | |
| College class | | | | 1 | 75 | | |
| Crippled Children's Service | | | | | | 1 | 200 |
| Day Care Centers | Church sponsored | 16 | 395 | 33 | 2474 | | |
| | Non-Sectarian | 13 | 419 | 25 | 1757 | | |
| Diaper Service | | | | | | 1 | 1000 |
| Health Department | | 1 | 2 | | | 1 | 5000 |
| Hospitals | | 3 | 90 | | | 1 | 300 |
| Mental Health Centers | | 2 | 17 | | | 2 | 1100 |
| Miscellaneous | | | | | | 10 | 5000 |
| Parent Groups | | 12 | 185 | | | | |
| Physicians | | 1 | 20 | 5 | 200 | 15 | 400 |
| Professional staffs | | 15 | 290 | | | | |
| Public Elementary Schools | | 34 | 1885 | | | 33 | 1880 |
| Public High Schools | | 8 | 312 | | | | |
| Telephone Requests | | | | | | | 710 |
| Total | | 119 | 4133 | 61 | 5346 | 40 | 15265 |

in response to telephone requests prompted by radio, television and newspaper publicity. Figure 1 describes the major CHILD CHECK publicity events and the number of parental requests for dairies.

The mayor declared November CHILD CHECK month. The Downtown Kiwanis Club donated $2,000 to produce a filmed public service announcement for television and to finance public relations consultation and materials. The county pediatric society and two hospital pediatric staffs were given group presentations; dairies were distributed at 20 pediatricians' offices; and one pediatrician co-authored an article on early childhood development which appeared in a major newspaper. The public school system purchased 11,700 diaries and requested that elementary schools sponsor group presentations. Subsequently 34 elementary school parent groups were given presentations. Three religious denominations included information about the campaign and how to schedule a group presentation in newsletters circulated city wide.

The Tennessee-Peabody Referral and Information Office, cited in the services brochure as the primary referral source for handicapped children, reported a weekly average of two to three calls prompted by the CHILD CHECK campaign during campaign months. The RIP program in Nashville received 113 referrals during the campaign, compared with 68 during the same period the preceding year, an increase of 66 percent. Thirty-nine (35%) of the referrals made during this period were directly attributable to the campaign. Thirty-four of these were generated by newspaper articles.

Fifteen of the home surveyed parents attended group instruction, 25 were exposed to the mass media campaign, and 22 were not exposed. By contrast seven of the telephone surveyed parents attended group instruction,

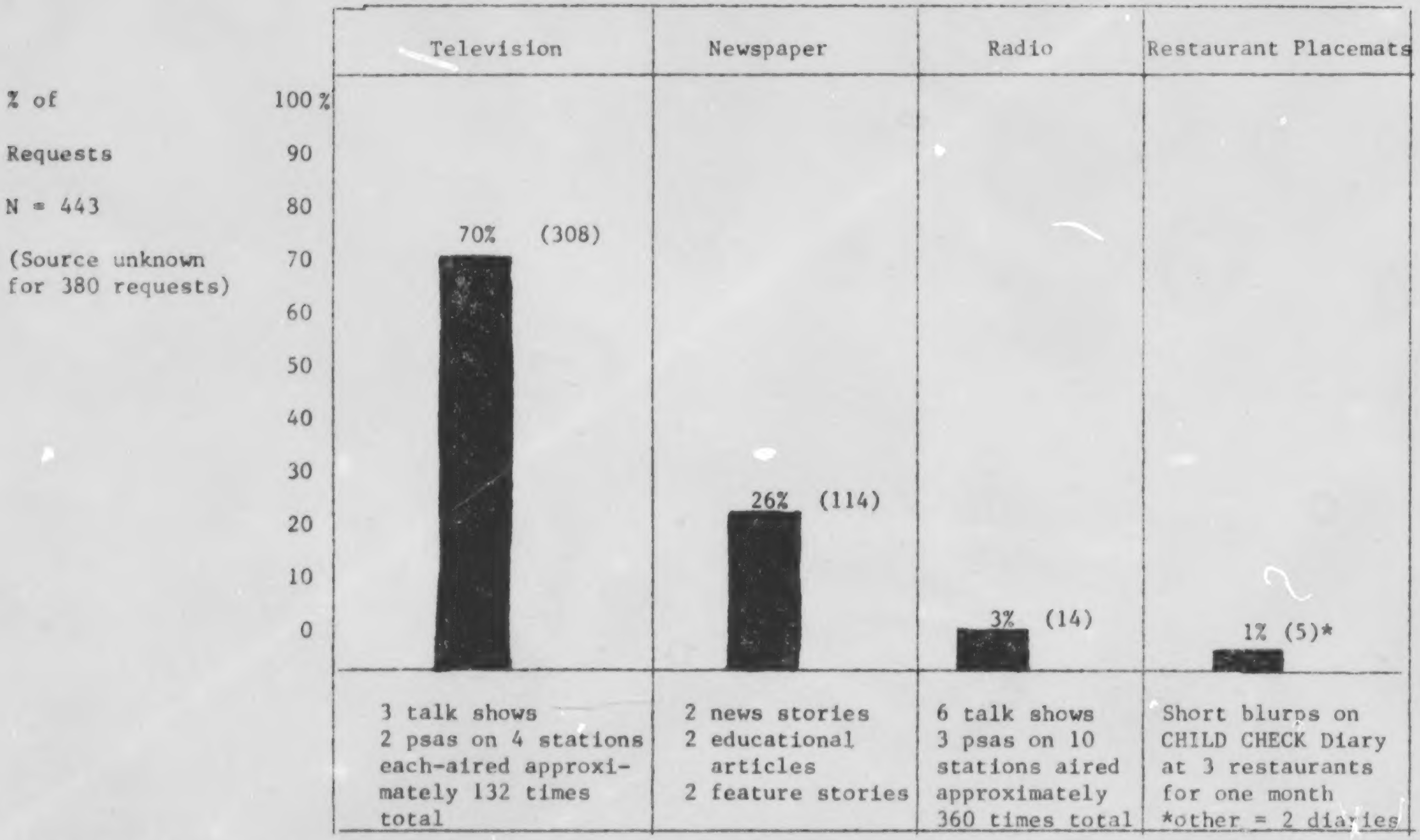

Figure 1. CHILD CHECK Diary Requests Prompted by Mass Media Campaign
Nashville 11/80-4/81
N = 823

25 were exposed to mass media and 74 were not exposed. For both the home and telephone surveyed parents there were no overall pre- to post assessment differences on the attitudinal, child development or legal rights scales for any of the group instruction, mass media or not exposed subgroups. Table 8 shows the mean scale scores on the pre- and post assessments on telephone and home surveyed parents.

The mean scale scores on legal rights increased, but not significantly, from pre- to post assessment for the group instruction, mass media, and not exposed home survey parents, as Table 8 illustrates. However, on seven legal rights items the group instruction parents showed gains, three of which were significant. Two other items on which group instruction parents did not show significant gains were answered correctly by all subjects on the post assessment. Parents' high scores on the pre assessment probably precluded statistically significant gains being made on the post assessment for these questions. On six of the legal rights items the mass media home surveyed parents made gains, two of which were significant. By contrast the not exposed parents showed five gains and one drop, none significant, and two items on which no change took place.

Prior to the CHILD CHECK campaign two home surveyed parents identified at least one of key services listed on the CHILD CHECK services brochure when asked: "If parents discover they have a handicapped child, whom do you think they should turn to for help?" compared with five on the post assessment. Four mass media parents identified at least one key service when asked that question on the pre assessment, compared with four on the post assessment. Non-exposed parents dropped

## TABLE 8

## NASHVILLE SURVEY RESULTS

### Home Survey Mean Scale Scores

| | Group Instruction n=15 | | Mass Media n=25 | | Not Exposed n=22 | |
|---|---|---|---|---|---|---|
| | Pre | Post | Pre | Post | Pre | Post |
| Attitudinal Scale (15 items)<br>lowest possible = 15<br>highest possible = 30 | 27.07 | 27.60 | 26.44 | 26.68 | 25.32 | 26.27 |
| Child Development Scale (27 items)<br>lowest possible = 27<br>highest possible = 54 | 46.80 | 47.60 | 46.08 | 46.40 | 45.09 | 46.86 |
| Legal Rights Scale (8 items)<br>lowest possible = 8<br>highest possible = 16 | 13.60 | 14.73 | 12.72 | 13.68 | 12.55 | 13.14 |

### Telephone Survey Mean Scale Scores

| | Group Instruction n=7 | | Mass Media n=25 | | Not Exposed n=74 | |
|---|---|---|---|---|---|---|
| | Pre | Post | Pre | Post | Pre | Post |
| Attitudinal Scale (5 items)<br>highest possible = 10<br>lowest possible = 5 | 8.0 | 8.43 | 8.16 | 8.40 | 8.07 | 8.31 |
| Legal Rights Scale (5 items)<br>highest possible = 10<br>lowest possible = 5 | 7.57 | 7.57 | 7.88 | 7.60 | 7.24 | 7.19 |

on knowledge of services from pre- to post assessment. When asked "What agencies in your community provide help or services to handicapped children?" 10 parents exposed to group instruction identified at least one key service on the pre assessment, compared with 15 parents on the post assessment; 21 mass media parents identified a key service on the pre assessment, compared with 20 on the post assessment, and non-exposed parents gained from 12 identifying a key service on the pre assessment to 15 on the post assessment. Little change in knowledge of services was demonstrated by telephone surveyed parents under any of the three conditions.

There were no differences between pre- and post assessment knowledge of developmental milestones under any of the conditions. There was a significant difference (p - .01) in the rate at which home surveyed parents attending group instruction received a diary compared with home surveyed parents exposed to mass media. There was no difference, however, in the rate at which parents receiving diaries under either condition used the diaries to monitor their children's development. Out of 15 parents attending group instruction 14 received diaries. Two (13%) did not use the diary at all, eight (53%) used it once, and four (27%) used it twice. Of eight mass media parents who received diaries, two (25%) did not use it, four (50%) used it once, and two (25%) used it twice. These same trends prevailed among telephone surveyed parents receiving diaries exposed to group (n = 7) and mass media (n = 6).

Recruiting surveyed parents to attend group instruction proved difficult, as had been the case in the rural campaigns. All home surveyed parents received telephone and written invitations to attend at least four presentations. Of these 15 (24%) attended. A more accurate predictor of unsolicited attendance can be drawn from the telephone surveyed parents, who did not receive invitations from RIP Expansion Project to attend. Out of a sample of 107 parents, seven (6.5%) attended.

Although all of the home surveyed parents received at least two written invitations to attend CHILD CHECK group instruction meetings explaining in detail what CHILD CHECK and the CHILD CHECK Diary were, and 75% of these also received follow-up phone calls, 22 (35%) of the home surveyed parents reported they had never heard of CHILD CHECK. This compares with the telephone surveyed parents, 72% of whom were not exposed to CHILD CHECK.

## School System Field Test

Training sessions for the school systems took place in November 1980, January 1981 and March 1981. Two representatives from each of 30 selected school systems attended. Average attendance at the workshops was forty-five. Trainees were given instruction on how to organize their communities, plan CHILD CHECK campaigns, conduct group instruction, obtain radio, television and newspaper publicity, and conduct a screening. See Appendix for the agendas of the training sessions.

Twenty-four school systems submitted data on their campaign activities. A total of 203 group representations were given to some 430 people in the 24 systems. In addition 7,146 diaries were distributed at 141 organizations across the state. Seven radio talk shows, 87 radio public service announcements, [illegible] newspaper articles, four television talk shows, six television public service announcements and seven television news shorts comprised the systems' CHILD CHECK activities. Seven systems conducted screenings of preschool children. Verbal reports indicated that numerous new referrals of handicapped children were made following group presentations, but that very few were discovered through diary distribution alone. These results coincide with the results of the rural campaigns which indicated that group instruction was more effective than mass media techniques in educating parents of your children.

# COMPONENT B

# RIP REPLICATION

# DEVELOPMENT

## Stimulation of Replication Training Sites

Information about RIP was disseminated through publications, professional conferences (see "Introduction") and telephone, mail and personal contacts. Preliminary requests for information were usually followed by a series of discussions between Component B staff and prospective sponsoring agency staff and representatives of agency boards of directors. During these negotiations assessments of probable need to establish a RIP program were made considering three major factors: (a) population, including numbers of preschool aged children in the target area; (b) community requests for preschool services to the prospective RIP sponsor, and (c) availability of alternative preschool services in the target area. Probable viability of a RIP program in the target area was examined with regard to the sponsoring agencies' ability to: (a) commit at least 75% of one staff member's time to operation of a RIP program and (b) to free the staff member to participate in eight to 10 weeks of training at RIP Nashville. Negotiations were conducted with 12 prospective RIP sponsors:

1. The Childrens Aid Society of Brant, Brantford, Ontario, Canada
2. Positive Education Program, Cleveland, Ohio
3. Overlook Mental Health Center, Knoxville, Tennessee
4. Sumner County Guidance Center, Hendersonville, Tennessee
5. Chula Vista City School District, Chula Vista, California

6. Niagara Child Development Center, Welland, Ontario, Canada
7. State Department of Human Resources, Lexington, Kentucky
8. Connecticut State Department of Education, Hartford, Connecticut
9. Association for Retarded Citizens, Manistee, Michigan
10. Montana Office of Public Instruction, Helena, Montana
11. Rutherford County Guidance Center, Murfreesboro, Tennessee
12. Lawrence County Mental Health Center, Lawrenceburg, Tennessee

Negotiations with five of the above agencies resulted in decisions to begin RIP programs. A copy of a sample agreement between one agency and the RIP Advisory Committee, Inc. is included in the Appendix.

## Continued Support and Consultation to Established Sites

The continued support provided by Component B staff included on-site consultation, telephone consultation, training of additional or replacement staff, sponsorship of an annual expansion conference in Nashville, and special assistance such as writing proposals for funding, or designing community relations activities. Detailed information about these activities is provided in the "Implementation and Evaluation" section to follow.

## Production of Materials for Replication Training

Because the level of grant funding for media production did not permit production of separate Component B replication training materials, Component B staff incorporated certain Component C training materials into the replication training program. Some were used as written for Component C; performance data from participants using these materials are included in the results of module training in the Component C "Implementation and Evaluation" section of this report. Others were revised and field tested with five RIP replication trainees.

## Adaptation of Materials for RIP Expansion Project Parent Training

Pilot training of RIP Expansion project parents using Component C materials was conducted by the Projects Consultant in the Columbia and Clarksville sites. With the assistance of Component B and C staff members and the RIP media module coordinator, former RIP parent Peggy Steele adapted the Component C training materials for future use in RIP parent training. The adapted materials included three self-instructional units for parents and a series of 10 videotapes with approximately 3.5 hours running time. Field testing of these materials will be completed in the summer of 1981.

## Analysis of the RIP Replication Process

The RIP Advisory Committee, Inc. appropriated $1,500 on December 7, 1978 to support a systematic examination of the RIP replication process. Ms. Sharon M. Innes, doctoral student at George Peabody College for Teachers of Vanderbilt University, conducted the study. Copies of her assessment instruments were included in the Performance Report: Project Year Two (The RIP Advisory Committee, Inc., Note 3). She submitted the completed 330 page report in May 1981. The results are summarized in the following section.

## IMPLEMENTATION AND EVALUATION

### Development of Replication Sites

During the July 1, 1978 through June 30, 1981 period three programs were certified as RIP replication sites. These programs are located in Cleveland, Ohio; Brantford, Ontario, Canada; and Hendersonville, Tennessee. Two more sites (located in Chula Vista, California and Manistee, Michigan) are operational and staff training has been completed but certification is pending as explained below.

Negotiations concerining the PEPPI Preschool Parent Centre, sponsored by the Children's Aid Society of Brant, Brantford, Ontario were completed prior to receipt of federal funds in the summer of 1978. Two staff members, Mr. George Speers and Ms. Millie Valian, completed RIP replication training in May 1978. A third staff member, Mr. Doug Fulcher, completed training in May 1979. The program was informally approved as a RIP replication site in June 1978 and formally certified in September 1978. A follow-up visit in December 1978 confirmed that the program conformed to the RIP model. Complete descriptions of negotiations and training are found in The Performance Report: Project Year One (The Regional Intervention Program Advisory Committee, Inc., Note 2).

The Early Intervention Center (West), Cleveland, Ohio represented the first RIP replication conducted by a replication site. Staff training for the EIC (West) was conducted during July and August 1978 by personnel from the already established Early Intervention Center (East) and Component B staff. The EIC (West) program opened in September 1978. The Component B director visited the program in October 1978 to confirm the program's adherence to the RIP model.

The third replication site established during this period was sponsored by the Sumner County Guidance Center in Hendersonville, Tennessee. Training was conducted January 15 through March 7, 1980, for Ms. Daryl Park. The program opened in April 1980, and was certified by the RIP Advisory Committee, Inc. as an official replication site in May, 1980. Regular site visits were made by the Component B Projects Consultant as described later in this report. The program was suspended in December 1980, when Ms. Park resigned. Training for a replacement staff member occurred February 23 through May 13, 1981. That staff member's employment with the Guidance Center was terminated prior to the reopening of the program. The Guidance Center director is currently seeking a replacement staff member.

The fourth replication site, The Northwest Michigan Parent Training Cooperative is sponsored by the Association for Retarded Citizens in Manistee, Michigan. Staff training for Mr. Bill Arnold (abbreviated to three weeks due to his extensive prior training and experience) was completed in November 1980. Certification of the site by the RIP Advisory Committee pends a visit by Component B staff to assess the program's fidelity to the RIP model.

The Positive Intervention Program, Greg Rogers Center for Exceptional Children, City School District of Chula Vista, California was begun in January 1979 by Ms. Lora Earnest. Ms. Earnest was trained and certified as a RIP Expansion staff member at the Cleveland East Center prior to her relocation to California. Her request for certification at the Chula Vista site was considered by the RIP Advisory Committee in May 1980. Certification pends a visit by Component B staff to verify adherence to the model. Funds for this visit have not been secured.

Negotiations with the Niagara Child Development Center, Welland, Ontario are under way. If negotiations result in a decision to replicate RIP, training and consultation will be provided primarily by the PEPPI staff in Brantford, Ontario.

## Continued Support and Consultation to Established Sites

Basic information regarding locations, sponsorship, funding levels and starting dates for all RIP Expansion projects is presented in Tables 9 and 10. Number of families served for each project year as well as total numbers served from respective starting dates through June 30, 1981, are presented for each RIP Expansion Project in Table 11. A summary of both telephone and on-site consultation hours provided to each Project by Component B staff for each project year are presented in Table 12.

Nine special training cycles in addition to those reported under "Development of replication sites" were conducted between July 1, 1978 and June 30, 1981. The 13 participants included replacement and additional staff members for existing sites.

RIP Expansion Conferences for staff and parents from all projects were underwritten by the RIP Advisory Committee, Inc. Details of the 1978 and 1979 conferences were provided in the Performance Reports for Project Years One and Two (The Regional Intervention Program Advisory Committee, Inc., Note 2; The RIP Advisory Committee, Inc., Note 3). The 1980 conference was held from October 1 through 3. A total of 19 staff and eight parents participated. A copy of the conference schedule is included in the Appendix.

Table 9

Profile of RIP Expansion Projects in Tennessee

June 30, 1981

| Project | Major Funding Source(s) | Approximate 1980-81 Funding Level[1] | Start Up Date |
|---|---|---|---|
| The RIP Expansion Project | Middle TN Mental Health Institute<br>RIP Advisory Committee, Inc.<br>Bureau of Education for the Handicapped | $180,000 | 9/74 |
| RIP: Paris, TN (Satellite - Trenton) | Paris Mental Health Center<br>RIP Advisory Committee, Inc. | Closed 10/1/78 | 4/75 |
| Upper Cumberland Preschool Intervention Project Cookeville, TN (Satellite - McMinnville) | Developmental Area Mental Health | $ 36,000 | 8/75 |
| RIP: Columbia, TN Morning Program<br>RIP: Columbia, TN Afternoon Program | Columbia Area Mental Health Center<br>Maury County United Givers Fund<br>Monsanto Chemical Corporation<br>RIP Advisory Committee, Inc. | $ 37,000 | 9/75 |
| RIP: Tullahoma, TN. | Multi County Mental Health Center<br>RIP Advisory Committee, Inc. | Closed 3/1/78 | 10/75 |
| RIP: Clarksville, TN | Harriet Cohn Mental Health Center<br>Montgomery County Association for Retarded Citizens<br>RIP Advisory Committee, Inc. | $ 24,000 | 4/77 |
| RIP: Bolivar, TN | Quinco Mental Health Center<br>Tennessee Office of Child Development<br>RIP Advisory Committee, Inc. | $ 23,640 | 1/78 |
| RIP: Franklin, TN | Williamson County Counseling Center<br>Tennessee Office of Child Development<br>RIP Advisory Committee, Inc. | Closed 12/31/80 | 2/78 |
| RIP: Hendersonville, TN | Sumner County Guidance Center<br>RIP Advisory Committee, Inc. | $ 25,000 | 4/80 |

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[1] Approximate 1980-81 Funding Level refers to direct costs only which include staff salaries and benefits, physical facilities, equipment and supplies

## Table 10

## Profile of RIP Expansion Projects Outside Tennessee

June 30, 1981

| Project | Major Funding Source(s) | Approximate 1979-80 Funding Level[1] | Start Up Date |
|---|---|---|---|
| Preschool Intervention Project<br>W. Hartford, Conn. | Capitol Region Education Council<br>State of Connecticut | $117,656 | 4/76 |
| Early Intervention Center (East)<br>Cleveland, Ohio | Positive Education Program<br>Greater Cleveland United Way<br>State of Ohio | $169,806 | 11/76 |
| Early Intervention Center (West)<br>Cleveland, Ohio | Positive Education Program<br>Greater Cleveland United Way<br>State of Ohio | $167,406 | 9/78 |
| PEP Preschool Parent Centre<br>Brantford, Ontario<br>Canada | Children's Aid Society of Brant | $ 98,000[2] | 10/78 |

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[1] Approximate 1980-81 Funding Level refers to direct costs only which include staff salaries and benefits, physical facilities, equipment and supplies.

[2] U.S. currency equivalent @ .83 conversion rate.

## Table 11

## Families Served by RIP Expansion Projects

June 30, 1981

| Project | Start Up Date | Target Children Siblings Served 7/1/80-6/30/81 | Total Families Served Through June 30, 1981 |
|---|---|---|---|
| RIP: Hendersonville, TN | 4/80 | 8/8 | 7 |
| RIP: Paris, TN (Satellite - Trenton) | 4/75 | Closed 10/1/78 | 67 |
| Upper Cumberland Preschool Intervention Project Cookeville, TN (Satellite - McMinnville) | 8/75 | 29/4 | 66 |
| RIP: Columbia, TN Morning Program | 9/75 | 27/15 | 73 |
| RIP: Columbia, TN Afternoon Program | 9/75 | 10/8 | 65 |
| RIP: Tullahoma, TN | 10/75 | Closed 3/1/78 | 21 |
| RIP: Clarksville, TN | 4/77 | 20/5 | 46 |
| RIP: Bolivar, TN | 1/78 | 11/3 | 26 |
| RIP: Franklin, TN | 2/78 | Closed 12/80 | 15 |
| Preschool Intervention Project Windsor, Connecticut | 4/76 | 24/11 | 150 |
| Early Intervention Center (East) Cleveland, Ohio | 11/76 | 85/36 | 163 |
| Early Intervention Center (West) Cleveland, Ohio | 9/78 | 70/36 | 110 |
| PEPPI Preschool Parent Centre Brantford, Ontario Canada | 10/78 | 79/31 | 122 |
|  | Totals | 363/157 | 931 |

## Table 12

## Direct Consultation Provided by Component B Staff to RIP Expansion Projects[1]

June 30, 1981

| Project | Total Hours Onsite Consultation Provided 7/1/80 - 6/30/81 | Total Hours Telephone Consultation Provided 7/1/80 - 6/30/81 |
|---|---|---|
| RIP: Hendersonville, TN | 91 | 14 |
| Upper Cumberland Preschool Intervention Project Cookeville, TN (Satellite - McMinnville) | 109 | 7 |
| RIP: Columbia TN Morning Program and Afternoon Program | 188 | 24 |
| RIP: Clarksville, TN | 172 | 18 |
| RIP: Bolivar, TN | 130 | 12 |
| RIP: Franklin, TN | 2 (Closed 12/31/80) | 2 |
| Preschool Intervention Project West Hartford, Connecticut | - | 6 |
| Early Intervention Center (East) Cleveland, Ohio | 38 | 8 |
| Early Intervention Center (West) Cleveland Ohio | 38 | 8 |
| PEPPI Preschool Parent Centre Brantford, Ontario Canada | 25 | 9 |
| TOTALS | 793 Hours | 108 Hours |

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[1] Does not include training, consultation, and conference hours provided at the Regional Intervention Program facility, Nashville, Tennessee.

## Study of the RIP Replication Process: Summary and Discussion

The study of the RIP replication process was conducted by Sharon Munn Innes. The following section is excerpted from her work (Innes, 1981, pp. 227-234).

This... [summary] reviews briefly the purpose of the investigation, investigative questions, design of the investigation, and major findings of the research project. Theoretical constructs developed as one aspect of the research process also are presented.

### The Purpose of the Investigation

The purpose of this investigation was to analyze and describe the program replication process, i.e., the process by which an innovative program model is transferred to sites geographically distant from the original program site. For the purposes of this investigation, the replication process was considered a social phenomenon, and the research effort was designed with the intent to present a holistic portrayal of this phenomenon. In a general sense, the purposes of this investigation included (a) an examination of the replication process as a means for expanding a service delivery system, and (b) an exploration of ecological and organizational variables that have potential for influencing the implementation of this process. Specifically, investigative procedures were designed to identify the degree to which five replication programs represent the original program model and to isolate factors that appear to influence program replication within and across these replication sites.

## The Investigative Questions

The original investigative questions were organized in relation to four identifiable components of the replication process: (a) the original program model as a developing program, (b) the original program model as a mature program, (c) the replication project, and (d) the replication programs. The questions were applied to the overall research effort, and they represented a structural frame for the research. It was assumed that the initial questions would be modified during the research process as new hypotheses emerged during the data collection procedures. The use of continuous data analysis procedures led to the reformulation of investigative questions contributing to the development of theoretical constructs of the replication process. The reformulated questions and the theoretical constructs were related to two different aspects of the replication process: (a) service delivery concerns of an expanding service delivery system, and (b) program integrity issues regarding the original program's design and its implementation at the various replication sites.

## The Design of the Investigation

The overall research design was a case study approach using multiple methods and triangulation of multiple data sources to examine the behavior setting (i.e., service delivery system) of an established replication project. This examination involved both the Regional Intervention Program, an intervention program for preschoolers and their parents, and The RIP Expansion Project. Retrospective data were collected from documents and multiple interviews to explore the initial operations of the original program model and initial replication efforts. A cross-site examination (using multiple interviews, field observations, and questionnaires) of five replication sites explored ongoing replication activities.

Two dominant research methods were used: (a) the focused interview, and (b) project-developed questionnaires. Respectively, each of these methods was selected as means for collecting qualitative and quantative data in an effort to explain the replication process. These methodological approaches were interactive with respect to a conceptualization of the research project and the examination of the replication process, and they contributed in major ways to differing aspects of the investigation. Specifically, qualitative methods were used primarily to examine delivery concerns, and quantitative methods were used primarily to examine program elements and the demographic characteristics of client/participants at the replication sites. The use of qualitative and quantitative methods was based on the presummposition that the "intertwining' of these methods held potential for more accurately describing and explaining a complex means for service delivery than would either method used alone.

## Major Findings

Major findings of this investigation included the identification of two separate, but strongly interacting, aspects of the replication vice delivery system that virtually cannot be ignored by service delivery agents), and program integrity issues (those characteristics of a program replication effort that are of interest to persons responsible for replicating a particular service delivery mode). These two aspects of the replication process were presented as theoretical frameworks, each containing several separate, but interacting, components. The theoretical framework regarding service delivery concerns included propositions related to program funding, program effectiveness, program utilization, and program stability. The theoretical framework regarding program integrity issues included propositions related to program worth; the influences of changing people, time, and space; program instruction; program loyalty; model conformity; and program essence.

Data collected indicate strongly that each aspect of the total replication process (i.e., service delivery concerns vis-a-vis program integrity issues) must be considered--in-theory or practice--in relation to one another. The reason for dual consideration of service delivery concerns and program integrity issues is related to the fact that the replication process is a means for service delivery. To consider only program integrity issues in the description and explanation of the replication process is to ignore the major function of the process: the delivery of human services.

Additional findings reviewed here represent two different dimensions of the investigation related directly to the theoretical constructs described. First, as a broader dimension related to both service delivery concerns and program integrity issues, several themes emerged from qualitative data that were construed as hypotheses suggesting the existence of certain variables having significant potential for either helping or hindering expansion/replication efforts. These themes, or variables, included (a) factors in the external environment, (b) local community characteristics, (c) sponsoring agency characteristics, (d) replication project characteristics, (e) replication program characteristics, and (f) client/participant characteristics.

An analysis of these variables indicated that a single service delivery concern, program funding, overrides the influences of all other variables with respect to local program development and the replication process. The significance of this particular influence (program funding) appears self-evident. The significance of this single variable is related directly to the fact that program funding is a necessary condition that holds the greatest potential for influencing all other variables in program development and the replication process. The extent to which other variables (local community characteristics, sponsoring agency characteristics, client/participant characteristics) ultimately influence the funding base appears to be highly interactive in nature. Also, it is indicated that these variables "nest" in such a way that they influence one another hierarchically. For example, local community factors appear to have some potential for influencing the sponsoring agency's support for the program which, in turn, influences program operations, client/participants, and, ultimately, the replication process.

The same analysis of variables influencing the replication process required a separate explanation of the influence of the replication project on the entire process. The replication project exists as a separate entity that interjects itself into local situations--offering both benefits and constraints to the existing service delivery system. The degree to which the existing system recognizes the benefits provided by the replication project, is able to utilize these benefits within the system (i.e., agency and community), and is capable of adapting to the constraints of the original program's design appears to promote support from the sponsoring agency. Findings indicate that securing and stabalizing program procedures in a manner that is mutually acceptable to the sponsoring agency and the replication project present a challenge to both parties in terms of recognizing the mutual rewards, or benefits, that each can achieve as a consequence of their contractual agreements.

A narrower dimension of the investigation produced findings related directly to program integrity issues (program utilization and model conformity). These findings were based primarily on quantitative data, and they indicated that program longevity is correlated highly with both program utilization and model conformity. Specifically, older programs are utilized to a greater extent and are more conforming to the original program model. Also, sponsoring agents of older programs are more knowledgeable regarding local program operations. However, the extent to which sponsoring agents and program practitioners agree with the essential characteristics, or philosophy, of the program's design appears to be more related to individual perspective and/or local circumstances than it does to program longevity. Further, the effect of time overrides the effect of distance between the original program model and the replication programs as the data indicated the absence of a relationship between geographic proximity (original program site to the replication sites) and model conformity.

It is important to emphasize that time, as a factor, correlates with various measurable aspects of the replication process. With respect to the particular replication process examined in this investigation, it seems that the ongoing training, consultation, and support activities provided by the replication project are important contributors to the trend toward the more conforming nature of the replication programs with the passage of time.

As a summary statement, key concepts of the knowledge production and utilization literature identified in chapter 1 were supported by data collected in this effort to explain the replication process. Specifically, an analysis of this process involved a description of the following concepts:

1. The characteristics of innovation (i.e., the original program model)

2. The characteristics of the information transfer (i.e., the replication process)

3. The characteristics of the situational field (i.e., the organization(s) and community settings)

4. The characteristics of persons involved in the total information dissemination, or replication process.

# COMPONENT C

# RIP-RELATED FIELD BASED TRAINING

## DEVELOPMENT

Component C (RIP related field-based training) was intended to provide opportunities for personnel working with young children in various settings to improve their skills in teaching young handicapped children. Field-based training addressed techniques employed at the Regional Intervention Program for Preschoolers and Parents in Nashville, Tennessee by parents working with their own children. The need for such training was related to the availability of personnel and services for young children in Tennessee (see application for HCEEP funding, Note 1).

There is not a specific special education training program in Tennessee for teachers working with preschool children. In addition, the number of handicapped children below age six not being served in Tennessee could be as high as 15,000.

Two sequential training manuals, Using Skills Effectively and Using Resources Effectively, a trainer's manual and a series of videotapes, were developed during the course of the grant. They were designed to teach basic skills in individual and classroom behavior management, and direct instruction and measurement through an alternation between in class lectures, exercises, role plays and on-the-job assignments.

Using Skills Effectively (USE) was designed to teach trainees to translate a particular child's needs into skill objectives, to use a program to teach a skill through direct instruction, and to evaluate the results of that instruction. Trainees assessed a child's existing skills in a given content area (language, preacademic and motor/self-help), selected a prewritten teaching program, taught the child and kept regular records of the child's performance.

Using Resources Effectively (URE) was designed to help professionals working with exceptional children enhance their teaching effectiveness by learning new ways to use two kinds of resources: existing materials and other adults. Trainees developed skill sequences and instructional programs using their own available materials. They were shown two systematic formats for group instruction, and how to train other adults, such as parents or volunteers, to use the specific instructional programs with children. Trainees were required to measure the progress of children taught according to the programs they designed.

Since the programs were field-based, trainees applied procedures between training sessions during their own work with children and brought their experiences back to class for discussion, suggestion, and revision. Trainees' written exercises and performance in simulations and field work were evaluated according to assigned criteria for each objective.

## Development and Formative Evaluation--USE

Using Skills Effectively was developed in 1978-79 by the Component C staff. Training needs were informally assessed through several meetings with prospective trainers at RIP Expansion Project sites in Tennessee. Based on this input, the following topic areas were developed for the program: (a) describing behaviors, (b) deciding where to begin--selecting a skill, (c) building skills--using consequences, (d) building skills--using signals, and (e) refining programming skills.

The training program was submitted to a panel of reviewers, six professionals from the fields of special education, mental health, child care and public health, in October 1978. Mean ratings on a 5-point Likert scale (1 lowest and 5 highest) for the overall program ranged from 3.8 for the sequence of topics to 5.0 for adaptability to trainees from a variety of professions. Reviewers suggestions were incorporated into the pilot edition. Further revisions of the manual occurred following several training cycles in Tennessee and Connecticut.

Concurrent with the production of written materials, requests for bids to develop a slide tape recruitment presentation and a series of videotapes to be used in training were sent to 12 local producers. The firm of Eleasari and Hahn, Inc., was chosen from the five bids received.

The slide tape production was delivered November 14, 1978. The show was submitted to a panel of seven reviewers from the mental health and education professions. On a 5-point Likert Scale, a mean rating of four was obtained in each of the three categories: overall interest of show, visual appeal, and content clarity. Pilot videotapes, totaling 79 minutes' running time, were delivered January 24, 1979. The tapes included the following titles: "Turning Off," "Identifying Signals," "Clear and Unclear Signals," "Praise," "Shaping and Prompting," and "Data Tape" (portraying five episodes of classroom activities).

Field testing of videotapes was conducted during Year One training cycles; each tape was tested upon initial use. Didactic tapes were tested for content clarity via written tests which were administered before and after viewing. Skill training videotapes were field tested by observing trainees' use of presented techniques in role plays following viewing. Tapes were considered acceptable if the mean posttest scores were 80% correct or higher or if 80% of the trainees met performance criteria for using the techniques. All tapes met field test criteria; therefore revisions were not made.

Development and Formative Evaluation--URE

The core URE program, which addressed preacademic skills, contained six units: (1) Identifying Skill Objectives, (b) Breaking the Skill into Steps, (c) Building a Program, (d) Teaching the Program: Two group formats, (e) Building Independent Performance, and (f) Teaching Another Adult to Teach a Program. Four additional units, three in the area of motor skills and one in language skills, were developed to supplement the core program.

The draft manual was sent on October 3, 1979 to a panel of reviewers, including two former USE trainers, and a special educator with extensive experience in teacher training and materials development. Reviewers gave the highest ratings to the program's length and appropriateness of topics (both mean ratings of 5 on a 5-point Likert scale) and lowest to clarity (mean rating 3.5). Revisions of the manual were made following the initial training cycles, and at the end of field testing.

Nineteen requests for bids to produce videotapes to accompany the URE program were sent in May 1979, to local media producers. Eleasari and Hahn, Inc. were chosen from the three bidders to produce the videotapes. The URE videotapes, totaling 82 minutes, addressed the following topics: interviewing parents, disruptive behavior, group teaching (unison and individual formats), error correction and training another adult. The tapes also included episodes for practicing data collection.

## Development and Formative Evaluation--Trainer's Manual

The trainer's manual, a guide for implementing USE and URE, was developed from June through August 1980, as a self-instructional workbook. The following topics were presented in the manual and accompanying videotapes: evaluation and feedback, instructions for didactic sessions, conducting site visits, and data collection. The video tapes were produced by Film House, Inc. of Nashville, one of the three media companies that submitted a bid. The tapes had a total running time of 34 minutes.

Prior to the completion of the videotapes, the manual was field tested by a resource person at a RIP Expansion site. Subsequently, reviews of the manual were obtained from RIP staff involved in community training, a special education professor of higher education, and a high school child care teacher. Revisions were made in the written materials on the basis of reviewer suggestions.

## IMPLEMENTATION AND EVALUATION

Twenty-two cycles of USE and URE training were conducted in six cities in Tennessee (Nashville, Bolivar, Columbia, Cookeville, McMinnville, and Tullahoma), and in Hartford, Connecticut; four cycles occurred during Project Year 1, five during Year 2, and 13 during Year 3. The 10 trainers included four program developers and six RIP Expansion resource or community training staff. The 321 tainees included: Head Start teachers and aides, day care center staff, home health educations, public school early elementary teachers, Regional Intervention Program parents, foster parents, graduate and undergraduate college students enrolled in special education courses, and high school students in child care classes.

A total of 74 children were taught during training cycles and an additional 94 children were reported during follow-up contacts to have benefitted from the training.

The following measures were used to evaluate training results: knowledge of content, performance of in-class objectives, performance of field objectives, progress of children instructed with the programs designed in training, and participants' satisfaction ratings of the content and format of training. Knowledge of content was evaluated by scores on pre- and posttests, often administered during the same session. Performance of in-class and field objectives was measured by direct observation or evaluation of written products using predetermined criteria. Child progress was judged to have occurred or not occurred using the following criteria:

1. Made progress--if three of the four most recent data points showed improvement from pretest, baseline, or first session and no decreasing trend was evident; in the case of programs with successive steps, movement to a more difficult step was considered progress over baseline, unless the child was at criteria on all steps upon initial presentation and there was no pretest data
2. Made no progress or can't tell--if the data showed no change in skill from pretest, baseline or first session; or the data were insufficient to judge progress
3. Regressed--if the data showed loss of skill for three of the four most recent data points (from baseline, pretest or first session) and no increasing trend was evident.

All measures were not necessarily applied in all cycles. Those measures applied were a function of the time allotted for the training, the trainer-trainee ratio, and the availability of children to teach.

Reliability of trainees' child performance data was assessed during 16 site visits to 11 trainees. Mean agreement between trainers and trainees was 98 percent. An additional six trainees submitted an audiotape of a teaching session with their data. Mean percentage agreement between trainers and trainees on data collected from audiotapes was 76 percent.

## Pilot USE Cycle

Nashville staff delivered 36 hours of training in the pilot cycle (December 11, 1978 through March 2, 1979) to seven home educators employed by the Tennessee Department of Public Health. A probe (consisting of a teaching simulation with standardized "learner" behaviors) was given before and after training to measure changes in the rate of participants' praise, descriptive praise, and contacts to off-task children. As shown in Table 13, trainees' behavior in these three tasks changed in the direction desired as a result of training.

TABLE 13

USE PILOT CYCLE-RESULTS OF PRE- AND POST TRAINING PROBE
($n$ = 7)

| Total Praise ($\bar{X}$ rate per minute) | | Descriptive Praise ($\bar{X}$ rate per minute) | | Off-task Contacts ($\bar{X}$ rate per minute) | |
|---|---|---|---|---|---|
| Pre | Post | Pre | Post | Pre | Post |
| 3.8 | 4.0 | 2.1 | 3.7 | 1.8 | 0 |

Results of all evaluation measures applied in the pilot cycle are shown in Table 14. Trainees mastered 84% of both the 57 in-class and the 71 field objectives. Pretests were not administered, but the mean posttest score was 76%. Six of the seven children taught (86%) made progress. Trainee satisfaction was assessed seven weeks following the end of training via Likert scales (range 1-4) and is displayed in Table 15. Revisions in assigned objectives, quizzes and the order of units were made subsequent to the pilot cycle.

TABLE 14

USE PILOT CYCLE- TRAINING RESULTS

| | Knowledge of content (% correct on post-test) | In-class objectives # att.[a]/Met | | Field Objectives # att.[a]/Met | | $\overline{X}$ satisfaction (Likert scale range 1 low-4 high) learning/enjoyment | | % of children making progress | Trainer-Trainee agreement (classroom data) |
|---|---|---|---|---|---|---|---|---|---|
| Home Health educators (n = 7) | 76% | 57 | 84% | 71 | 84% | 3 | 3.5 | 86% | 80% |

[a] att. = attempted

TABLE 15

USE PILOT CYCLE FOLLOW-UP SATISFACTION RATINGS

| | How much learned | How often used skills covered in training | Feelings about training program | Feelings about the trainer |
|---|---|---|---|---|
| Mean rating n = 7 | 3 | 3 | 3 | 4 |
| Scale descriptor for $\overline{X}$ rating | 3 something | 4 often | 3 liked | 4 liked a lot |

## USE and URE Training Cycles

Evaluations of the remaining training cycles will be reported according to two categories, preservice and inservice training. Preservice training included five USE cycles with 60 high school students, one URE cycle with nine college graduate and undergraduate students in special education, and one USE cycle with four students or parents at another university. Inservice training was categorized according to trainer (Expansion Project staff or developers) and population (day care, public health and Head Start personnel, teachers, or RIP-enrolled parents):

1. RIP Expansion project training included one USE cycle conducted for 30 Head Start teachers in Bolivar, Tennessee; 14 Head Start teachers in Columbia, Tennessee; 15 Head Start teachers in Tullahoma, Tennessee; 10 public health nurses and home educators in McMinnville, Tennessee; and six USE cycles and one URE cycle conducted for 40 day care professionals in Hartford, Connecticut.

2. Public school training included one USE cycle for 11 early elementary or resource teachers from Metropolitan Nashville Public Schools and one URE cycle for four of these USE participants.

3. Parent training included modified USE cycles conducted for parents at the Sumner County RIP (Hendersonville), parents at the Columbia RIP, and parents at the Cookeville RIP.

Data will also be reported on module training which included delivery of one or two program units to high school and college courses, RIP teaching techniques classes, and new RIP Expansion staff.

## Preservice Training

Six groups of students from three local high schools participated in USE training during Project Years Two and Three. Arrangements for training at two of the schools were made through the director of home economics for the Metropolitan Nashville school system. Child care teachers from two different high schools requested that training be incorporated into their classes. Training was conducted at one school from October through November 1980. The cycle was completed before final arrangements for placing students in local day care centers were made. Training was conducted at the second school between November and December 1980. Students at this school interned at a nursery school that served 20 three to 5-year-old children on the high school campus from Tuesday through Thursday. Students rotated through one week cycles in three different activities: (a) assisting in the nursery school, (b) observing the children, and (c) completing independent study assignments. Training for students from the third high school, a private school, was provided as an integral part of a one month internship at the RIP Nashville program. Groups of three and five students participated during January 1980, and January 1981, respectively.

The results of training evaluation are shown in Table 16. All groups showed a gain in knowledge (measured by comparison of percentage correct on pre- and posttests). Completion of assigned in-class objectives ranged from 65% to 94% across groups. Mean percentage of field objectives completed ranged from 60% to 100 percent. Those students who worked with children during training scored higher on all performance measures than those who did not. High school 3 was the only group that trained children

TABLE 16

RESULTS OF PRESERVICE USE TRAINING

| Cycle | Knowledge |  |  | Performance |  |  |  | Child Progress |  |  | Satisfaction |  |  |  |  |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
|  |  |  |  |  |  |  |  |  |  |  | During |  | Follow-Up |  |  |
|  | Pre | Post | Change | Class |  | Field |  |  |  |  |  |  |  |  |  |
|  |  |  |  | # Att.[a] | % Met | # Att.[a] | % Met | N w/data | N taught | % progressed | Content | Interest | % Reply | Still use often[b] | # of other children trained |
| High School #1 (did not teach children during training) _n_ = 20 | 23 | 59 | 42 pts | 52 | 65% | NA |  | none | taught | NA | 3.6 | 3.3 | NA | NA | NA |
| High School #2 (taught children) _n_ = 16 | 23 | 91 | 68 pts | 15 | 87% | 22 | 67% | NA | NA | NA | 3.3 | 3.4 | NA | NA | NA |
| High School #2 (taught children) _n_ = 16 | 24 | 86 | 66 pts | 16 | 81% | 28 | 100% | NA | NA | NA | 3.4 | 2.9 | NA | NA | NA |
| High School #3 (taught children interned at RIP, 1980, _n_ = 3 | 63 | 92 | 29 pts | 18 | 94% | 9 | 89% | 0 | 3 | NA | 3.8 | 3.7 | NA | NA | NA |
| High School #3 (taught children interned at RIP, 1981, _n_ = 5 | 64 | 90 | 30 pts | NA |  | 15 | 60% | 4 | 5 | 100% | 3.5 | 3.3 | NA | NA | NA |
| Local university _n_ = 4 | 57 | 85 | 28 pts | 8 | 38% | 13 | 69% | 2 | 3 | 100% | 3.7 | 3.7 | 33 | 100 | 0 |

[a] Att. = attempted

[b] 3 or 4 rating

using programs; all four children trained made progress. Although the students at high school 2 did not teach from programs, they did administer posttests in the spring for the six skills on which the children were pretested during USE training in the fall. Satisfaction with training as rated on Likert scales describing content and interest of the programs were similar across groups.

One USE cycle was offered as a continuing education course entitled "Parenting Exceptional Children" at a local university. Data from this cycle are included in Table 16. Trainees met 39% of the assigned in-class objectives and 69% of the assigned field objectives. The mean knowledge gain was 28 percentage points; the mean posttest score was 85 percent. A total of three children were taught during training; however, only two trainees reported child progress data. Those two children made progress.

Nashville staff delivered URE training to six college graduate and three undergraduate special education students enrolled in an early education course during the spring semester of 1980. The students were divided into two sections (graduate and undergraduate); each section received approximately 16 hours of training and completed five units per cycle. Data from this cycle are shown in Table 17. Mean performance on both in-class and field objectives surpassed performance (graduate and undergraduate sections combined) in all other cycles; 97% of the in-class objectives and 99% of the field objectives were completed. Data were submitted on six of the nine children taught during this cycle; four of these six children made progress.

## TABLE 17

## RESULTS OF URE PRESERVICE TRAINING

| | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | Satisfaction | | | | |
| | Knowledge | | | Performance | | | | Child Progress | | During | | Follow-up | | |
| Cycle | | | | Class | | Field | | | | | | | | |
| | Pre % cor.[a] | Post % cor.[a] | Change % age points | # Att.[t] | % Met | # Att. | % Met | n | % Progressed | Content | Interest | % Reply | Still use often | % of other children trained |
| Graduate Students n = 6 | 70 | 96 | 27 | 36 | 94% | 42 | 97% | 5 | 60% | 3.4 | 3.3 | c | NA | NA |
| Undergraduate Students n = 3 | 30 | 84 | 55 | 27 | 100% | 30 | 100% | 1[d] | 100% | 3.7 | 3.5 | NA | NA | NA |

[a] cor. = correct

[b] att. = attempted

[c] No follow-up due to end of semester

[d] Only one trainee submitted child data

## Inservice Training

### 1. RIP Expansion Project Training

The Bolivar RIP resource staff member trained 15 Head Start teachers and 19 aides using three units of the USE program from August 19 to September 22, 1980. Data, reported in Table 18, show that trainees met 64% of the 56 objects assigned and the mean knowledge gain was seven percentage points (range -19 to +48).

The Columbia RIP resource person contracted to deliver USE training to 34 teachers employed by the Elk and Duck River Head Start program from March through May 1979. The Columbia staff member trained 17 teachers at the Columbia Area Mental Health Center and former RIP staff at the Multi County Mental Health Center in Tullahoma, trained the other 17. As shown in Table 18, Columbia trainees met 93% of assigned in-class objectives and 83% of assigned field objectives. Progress was made by 38% of the children they taught. Tullahoma trainees met 88% of assigned in-class objectives, 82% of assigned field objectives, and 60% of the children they taught progressed. Trainers did not administer pretests to trainees; therefore, only posttest scores are reported for these two groups. The mean posttest score for Columbia trainees was 80% and the mean score for Tullahoma trainees was 83 percent.

Ten home health educators were trained by the Cookeville RIP resource person between March and June 1979. Their mean posttest score was 83% correct (see Table 18). Of the 52 in-class and 60 field objectives assigned, 94% and 75% respectively were met while 57% of the 10 children taught made progress.

Six USE cycles were conducted in Hartford, Connecticut; three in 1979-80 were taught by the RIP director, and three in 1981 were taught

## TABLE 18

## RESULTS OF USE INSERVICE TRAINING

| Cycle | Knowledge |  |  | Performance |  |  |  | Child Progress |  | Satisfaction During |  | Follow-up |  |  |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
|  | Pre | Post | Change | Class |  | Field |  | n | % making progress | Content | Interest | % Reply | Still use often | # of other children trained |
|  |  |  |  | Att.[a] | Met | Att.[a] | Met |  |  |  |  |  |  |  |
| Bolivar n = 34 | 64% | 70% | 7 | 0 |  | 56 | 64% | NA | NA | NA | NA | 29% | 75% | 4 |
| Columbia n = 17 | NA | 80% | NA | 54 | 93% | 53 | 83% | 13 | 38% | 3.8 | 3.9 | 86% | 92% | 37 |
| Tullahoma = 17 | NA | 82% | NA | 77 | 88% | 62 | 82% | 15 | 60% | 3.3 | 3.2 | 93% | 100% | 14 |
| McMinnville n = 10 | NA | 83% | NA | 52 | 94% | 60 | 75% | 10 | 57% | 3.0 | 2.9 | 70% | 86% | 21 |
| Connecticut #1 n = 14 | NA | NA | NA | NA | NA | NA | NA | 8 | 63% | 4.5[b] | 4.6[b] | 77% | 100% | 4 |
| Connecticut #2 n = 6 | NA | NA | NA | NA | NA | NA | NA | 6 | 100% | 4.8[b] | 4.9[b] | 100% | 100% | 0 |
| Connecticut #3 n = 5 | NA | NA | NA | NA | NA | NA | NA | NA | NA | 4.4[b] | 4.6[b] | 63% | 80% | 4 |
| Connecticut #4 n = 6 | 71% | 75% | 4 | 26 | 85% | 16 | 94% | 4 | 100% | 3.7[b] | 4.5[b] | 83% | 60% | 5 |
| Connecticut #5 n = 3 | 67% | 81% | 14 | 21 | 76% | 12 | 83% | 3 | 100% | 3.7 | 3.7 | 100% | 100% | 1 |
| Connecticut #6 | 47% | 70% | 22 | 23 | 96% | 24 | 79% | 6 | 67% | 3.1 | 3.3 |  |  |  |
| Metro n = 15 | 30 | 80 | 48 | 14 | 71% | 32 | 53% | NA | NA | 3.2 | 3.3 | 75%[c] | 67% | 3 |

a attempted  b- five point Likert scale  c- Four trainees received follow-up by the RIP community trainer. A total of 25 persons participated in the second three. Performance data are shown in Table 18. Trainees' knowledge increased in all three cycles for which data were collected. Trainees met 76% or more of all assigned objectives and 22 of the 27 children for whom data were reported made progress.

One cycle of URE training was conducted in Connecticut in May 1981. The three participants were former USE trainees. Data from this cycle are included in Table 19. Trainees' mean posttest score was 87% with a mean knowledge gain of 25 percentage points. Trainees met all of the three class and 24 assigned field objectives.

2. Public School Training

The USE and URE programs were offered for inservice credit through the Metro Nashville school system inservice program. Two five week cycles were conducted from October 2 through December 18, 1980. Teachers received inservice credit for each session attended. Attendance varied widely across sessions in these cycles.

Data are included in Table 18 for trainee knowledge, performance, child performance, and follow-up ratings. Fifteen trainees attended at least one USE session. The mean pretest score for USE was 30% while the mean posttest score was 80 percent. Fourteen in-class objectives were attempted and 71% were met; 32 field objectives were assigned and 53% were met. Five weeks of USE training did not allow enough time for trainees to collect sufficient child data to evaluate progress. Four USE trainees attended URE training. Data are shown in Table 19. Mean pretest and posttest scores were 40% and 79% respectively. On the seven in-class and six field objectives assigned, trainees met 86% and 100%

## TABLE 19

## RESULTS OF INSERVICE URE TRAINING

| Cycle | Knowledge | | | Performance | | | | Child Progress | | Satisfaction | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Pre | Post | Change | Class # att.[a] | % Met | Field # att.[a] | % Met | n | % making progress | During Content | Interest | % Reply | Follow-up Still use Often | # of other child-ren traine |
| Connecticut n = 3 | 62 | 87 | 26 | 3 | 100% | 24 | 100% | NA | NA | 3.6 | 3.6 | NA | NA | NA |
| Metro n = 4 | 40 | 79 | 38 | 7 | 86% | 6 | 100% | 3 | 67% | 3.6 | 3.6 | 75% | 100% | 7 |

[a] att. = attempted

respectively. Two of the three children taught made progress.

3. Parent Training

USE training cycles were conducted by the RIP Expansion Project consultant for RIP parents in Clarksville and Columbia, Tennessee. The training emphasized didactic knowledge only since performance skills had already been addressed in the RIP treatment program. Data for the Columbia cycle is shown in Table 20. Columbia parents' mean posttest score was 86%, a gain of 34 percentage points over the mean pretest score.

Module Training

In addition to complete USE and URE cycles, 11 individual unit modules were conducted. Two USE units and three URE units were used as portions of high school and college classes and training for prospective Expansion Project staff. Data are grouped according to types of trainees and reported by individual units presented. USE data are reported in Table 20 and URE data are shown in Table 21. In general, posttest and change scores were higher in module training using the URE program than in training with USE. The results indicated, however, that modules from both programs could be incorporated into course content for a variety of learners.

## TABLE 20

## RESULTS OF MODULE TRAINING-USE

| Group | | | Knowledge | | | Performance | | Satisfaction | |
|---|---|---|---|---|---|---|---|---|---|
| | N | Unit | Pre | Post | Change | In-Class | Field | Content | Interest |
| Columbia parents n = | 14 | 1,3,4,5<br>2 (no posttest) | 52 | 86 | 33 | NA | NA | NA | NA |
| Nashville RIP Parents (Teaching Techniques) | 4 | Turning off VTR | 85 | 97 | 12.5 pts | | | | |
| | 4 | Praise VTR | 52 | 77 | 25.3 pts | NA | NA | NA | NA |
| | 4 | Shaping VTR | 85 | 95 | 10 | | | | |
| | 7 | Signals VTR | 71 | 76 | 5 | | | | |
| High School 1 (Child Care Class) | 21 | 1 | 30 | 53 | 23 | NA | NA | NA | NA |
| | 21 | 2 | 21 | 36 | 15 | | | | |
| High School 1 (Child Care Class) | 20 | 1 | 29 | 61 | 32 | NA | NA | NA | NA |
| | 20 | 2 | 14 | 34 | 20 | | | | |
| Peabody (Behavior Disorders Course) | 8 | 1 | 62 | 76 | 14 | | | | |
| | 8 | 2 | 40 | 100 | 60 | NA | NA | NA | NA |
| | 8 | 3 | 62 | 79 | 17 | | | | |
| | 8 | 4 | 49 | 75 | 26 | | | | |
| TSU (Child Development Course) | 16 | 2 | 18 | 51 | 33 | NA | NA | 3.7 | 3.6 |

## TABLE 21

## RESULTS OF MODULE TRAINING-URE

| Group | N | Unit | Knowledge |  |  | Performance |  |  | Satisfaction |  |
|---|---|---|---|---|---|---|---|---|---|---|
|  |  |  | Pre | Post | Change | In-Class att[a] | % Met | Field | Content | Interest |
| Peabody graduate (Applied Behavior Analysis Course) | 9 | 4 | 12.5 | 72 | 58.5 | 21 | 90% | NA | 3.7 | 3.4 |
| High School 2 (Child Care Class) | 10 | 4 | 20.5 | 67.6 | 42.4 | 22 | 82% | NA | 3.9 | 3.1 |
| High School 2 (Child Care Class) | 12 | 4 | 12.3 | 48.3 | 41.25 | 21 | 52% | NA | 3.7 | 3.0 |
| Prospective Expansion Project Staff | 3<br>2<br>2 | Motor II<br>VI<br>III | 13<br>29<br>61 | 91<br>80<br>94 | 78<br>51<br>33.5 | 3<br>2<br>NA | 33%<br>100%<br>NA | NA<br>NA<br>NA | NA | NA |
| TSU | 3 | VI | 13 | 83 | 70 | 3 | 100% | NA | 4 | 3.6 |
| High School 3 (RIP Intern) | 5<br>5 | IV<br>VI | 11<br>25 | 76<br>86 | 60<br>61 | NA | NA | NA | 3. | 3. |

[a] att. = attempted

## LONGITUDINAL FOLLOW-UP STUDY

(Manuscript submitted for publication)

# Long-term Effects of Oppositional Child Treatment with Mothers as Therapists and Therapist Trainers[1,2]

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# Abstract

The follow-up data reported herein represent a long-term (three to nine years out of treatment) evaluation of 40 children who were clients of the Regional Intervention Program (RIP) from 1969 to 1978. As 3-, 4- and 5-year olds, these youngsters exhibited severe and prolonged tantrums, continual opposition to adults' requests and commands, and physical aggression toward parents. Each of the 40 children and their mothers participated in a standardized intervention package modeled after Wahler's Opposition Child Treatment. Briefly, the results from school- and home-based assessment showed that: a) commands, demands, or requests made by parents were likely to be followed by former clients' compliance; b) former clients' social interactions in the home were overwhelmingly positive and their non-social behavior was by and large appropriate; c) parent behavior in the home setting was consistent with the child management skills taught many years ago; d) there were no differences between the compliant, on-task, social interaction and appropriate/inappropriate non-social behaviors of former clients and randomly selected class peers; e) there were no differences in teachers' commands, negative feedback, positive social reinforcement, and repeated commands that were directed toward either former clients or randomly selected class peers; f) both teachers' and parents' rating of former clients on the modified Walker Problem Behavior Checklist were highly correlated; g) there were no differences in teachers' rating of former clients and class peers; and h) of all the studied demographic variables only age treatment began and family intactness were related to current levels of behavior.

Efforts to alter parent-child problem interactions by teaching parents to use social learning techniques generally have met with considerable success (O'Dell, 1974). Not only are parent-child interactions improved in home and clinic settings (Strain, Young, & Horowitz, 1981), but these behavior changes may persist in the absence of treatment and generalize to other stimulus conditions (Wahler, 1975).

Research to investigate the maintenance and generalization of parent training outcomes is limited in number, methodology and scope. Where posttreatment maintenance has been concerned, most investigators have conducted a single follow-up assessment (e.g., Allen & Harris, 1971). Where more extensive follow-up assessment has been provided, another problem exists. The multiple observational follow-ups conducted by Patterson and his colleagues (1974a, b) and Wahler (1975) represent occasions for continued treatment with several families. Since both investigators noted that a number of families reverted to their pretreatment interaction patterns, additional, though less intense instruction was given. Thus, as Forehand and Atkeson (1977) point out, follow-up by these investigators cannot necessarily be equated with an interval of non-treatment.

An additional methodological issue regarding posttreatment maintenance concerns the time interval involved. The most lengthy follow-up reported to date has been three years (Rimm, Vernon, & Wise, 1975). However, the validity of the data is questionable given the exclusive use of parent opinion rather than more objective behavioral measures. In general, where direct observational methodology has been used, follow-up information has not been collected beyond two years (Wahler, 1975). It also seems apparent that no particular conceptual rationale has been used to select follow-up time intervals.

A problem area for both maintenance and generalization studies has been the number of families involved. Patterson and Fleishman's (1979) follow-up of 33 problem families represents the largest sample studied to date. Yet, the norm for the literature is far less. As Strain et al. (1981) note, predictions about the course of posttreatment behavior change can only be developed by examining aggregate data from large numbers of families exposed to similar training. By and large, the number of clients that have been followed in individual studies generally has precluded any statistical analysis of variables that may correlate with overall treatment success.

The generalization of child behavior change to settings in which parents are not present is a largely unstudied and methodologically-clouded issue. Studies reported to date have focused upon setting generality from home to school. Where teacher verbal behavior has been the measurement method, several authors reported generalized effects (Bernal, 1969; Johnson & Green, 1975; Mathis, 1971). In three studies in which direct observational data were collected (Johnson, Bolstad, & Lobitz, 1974; Wahler, 1969, 1975), no positive treatment gains were noted in the school setting. The obvious explanation for the lack of school behavior change is that the significant social agent changed from parent to teacher, and the contingencies on target behaviors were altered as well. It is also possible that the measures taken in the school setting underestimated the influence of behavior covariation (e.g., Strain & Ezzell, 1978; Wahler, 1975), and thus important collateral changes may have gone unassessed. For example, if a child indirectly learns a functional skill such as attention to adult verbal behavior during intervention, this skill may set the occasion for improved performance during instructional interactions with teachers. The child's attentiveness may alter teacher behaviors in the same way that instructional antecedents and consequences obviously influence child performance (Hill & Strain, 1977).

The present follow-up study attempts to address several of the methodological issues raised here. First, a large number of families (40) was studied, each having been exposed to identical treatment procedures. Second, multiple assessments were conducted on these clients, who had not been involved in treatment for a period ranging from three to nine years. The minimum of three years out of treatment was chosen in order to assess children's behavior in a school environment where academic performance would be demanded. Third, original target behaviors were assessed in the home environment, along with other behaviors predictive of successful child performance in school settings. Fourth, various family and child demographics were obtained in order to investigate uncontrolled variables that may be predictive of long-term maintenance and generalized behavior change. Finally, in order to determine the social validity of posttreatment behavior change, data were collected on four randomly selected age and sex peers from the same classroom setting in which each former client was enrolled; and both parent and teacher completed a modified Walker Problem Behavior Checklist on each target child (teacher also completed checklist on randomly selected peers).

## Method

### Subjects

A total of 56 families in the Nashville, Tennessee area, who were clients of the Regional Intervention Program (RIP) from 1969 to 1978 comprised the initial sample for this follow-up study. Criteria for selecting families were: (a) child had entered or completed the first grade; (b) families currently resided within 20 miles of the program; (c) families were originally referred to the program because of child oppositional behaviors (e.g., refusal to follow requests, tantrums, aggression toward parent; (d) parents and children had met behavioral criteria for exiting program; namely, generalized behavior change in the home setting for both parties. The final group of 40 families represented 90% of the total number of families that could be contacted to solicit participation. Of the families that refused participation, all stated that they were concerned that their child would inadvertently be identified as a former client, and this would adversely influence school personnel. A detailed description of participating families follows:

The vast majority of these clients were referred to RIP by pediatricians, psychologists, and psychiatrists. Most of the children had been involved unsuccessfully in some type of educational program or insight-oriented therapy prior to their experience at RIP. Table 1 below summarizes available demographic information on these families.

The 40 former RIP clients were located in their elementary and middle school classes with the aid of parents. The principal of each school was contacted by the research staff and informed of the purpose

TABLE 1

CHILD AND FAMILY DEMOGRAPHIC VARIABLES FOR FOLLOW-UP GROUP (N = 40)

| Variables | Representative Data | |
|---|---|---|
| | Range | Mean |
| Child's Age upon Entering Program (mo.) | 17-70 | 35.6 |
| Birth Order | 1- 6 | 1.4 |
| Number of Siblings | 0- 4 | 1.0 |
| Percent Attendance of Scheduled Clinic Appointments | 50-100 | 83 |
| Mother's Age (years) | 18-48 | 27 |
| Sex of Child | 83% male | 17% female |
| Race of Child | 75% white | 25% other |
| Family Structure | 87% intact | 13% single parent |
| Family Income Level | below 3,000 - 15%<br>3,000-6,000 - 12.5%<br>6,000-9,000 - 17.5%<br>9,000-12,000 - 27.5%<br>12,000-15,000 - 17.5%<br>15,000 + - 10% | |
| Mother's (primary treatment agent) Educational Level | below 8th grade - 12.5%<br>9th-12th grade - 50%<br>Some college - 20%<br>college diploma - 17.5% | |

of the follow-up. The principals were told that it was essential that they not divulge this information to any teacher, parent, or child. To further preserve client anomymity and reduce any reactive effects of observation, all children in each designated class took home a permission letter for inclusion in a study on "school adjustment." Then, four same sex age peers were selected randomly in each class along with the target child. Thus, a total of 160 class peers, 132 males and 28 females, were selected for observation and teacher ratings in the school setting. Absenteeism by three students during the course of the study reduced the final number of class peers to 157.

## Treatment

The RIP facility is a data-based treatment program that focuses on teaching parents of oppositional children differential attention procedures in order to manage their child's behavior in a positive fashion. Structural descriptions of the program can be found in Ora, 1972; Snyder, Sullivan, and Manning, 1974; and Hospital and Community Psychiatry, 1976, 27, 728-731 (Gold Award description).

Families who entered the program with oppositional children were assigned to the Generalization Training (GT) module. The settings used for GT sessions were replicas of rooms found in most homes (e.g., bathroom, kitchen, bedroom, living room). Each room was equipped with a one-way mirror and ceiling microphones to provide complete visual and auditory access to parent-child interactions.

Parent-child dyads (in all 40 cases the mother was primary therapist) typically were scheduled for one 20-minute GT session four to five days per week. In addition, parents attended a weekly "Theory Class" in which various social learning principles were taught by parents whose children had previously been program clients. Prior to beginning any GT sessions, new parent-child dyads were assigned to a supervising parent (again, a former and successful client). Where possible, new mother and supervisor were matched with respect to problem behaviors exhibited by their children. The supervising parent explained to the new parent that she was to request her child to play with 10 different toys during a 20 minute play period. This format of oppositional child training was first developed by Wahler, Winkel, Peterson, and Morrison (1965). During each GT session a trained mother, usually the supervisor and/or a reliability assessor, recorded interaction data. Broadly defined categories of oppositional and cooperative child behavior were recorded along with mother attention to these two behavior classes. Every two minutes an observer would signal the mother to request that her child begin playing with a new toy. Following each session, mothers received specific feedback on their child's level of cooperation and their attention to positive and negative behaviors. Parents also graphed daily data on their performance and that of their child. Often these feedback sessions found supervisory parents conducting brief roleplay and rehearsal sessions with parents in order to demonstrate and encourage proper management techniques.

Each family in GT proceeded through a predetermined sequence of treatment. During baseline, several days (usually 3 to 5) of non-intervention were used to assess child and mother problem behaviors and establish a stable level of behavior from which to judge the magnitude and direction of behavior change during treatment. Of the 40 families in this study, children were typically found to spend the vast majority of each 20 minute session engaged in oppositional behavior. Moreover, almost all mother attention events were directed to deviant behaviors.

The second treatment phase, designated as Differential Reinforcement I, saw the parent instructed in various social learning techniques. Instructional procedures used with mothers included: a) written materials describing techniques; b) modeling (live and videotape); c) role playing and rehearsal; and d) feedback on performance. This phase continued until child behavior was appropriate 85% of the time across three consecutive sessions and parent attention was correctly applied to appropriate behavior 85% of the time across a similar number of sessions. On the average, mothers in the follow-up group met criterion within 12 sessions whereas the child's appropriate behavior reached criterion, on the average, within 16 sessions.

The third treatment phase, Reversal, lasted from one to three sessions. Mothers were told to attend to any oppositional behaviors and ignore all cooperative responses. This phase was designed with two purposes in mind. The first was to provide a demonstration of functional control over oppositional behavior. Second, this phase provided parents with a powerful example that their behavior in fact was responsible for their child's improved performance. Early clinical experience in the program indicated that many parents attributed child progress to a variety of extraneous variables (e.g., getting older, changing diet) prior to the Reversal phase.

In the fourth and final phase of GT intervention, mothers once again began to socially reinforce cooperative behavior and ignore oppositional responses. During this Differential Reinforcement II phase, mothers were given specific instructions regarding the leaning of reinforcement for cooperative child behaviors. Moreover, programming in the home setting was instituted. This phase continued until child cooperation was maintained in the home and clinic at or above 85% of the time under conditions of minimal adult attention. It was not unusual for cooperative behavior to maintain at criterion levels with five or less parent attention events per 20 minute session. This phase of treatment averaged 35 clinic sessions, with a range of 10-90 sessions.

Table 2 below summarizes the daily in-clinic range and mean percent of child compliance in each phase of treatment.

TABLE 2

RANGE AND MEAN PERCENT OF CHILD COMPLIANCE ACROSS ALL TREATMENT CONDITIONS

| Baseline | | Differential Reinforcement I | | Reversal | | Differential Reinforcement I | |
|---|---|---|---|---|---|---|---|
| Range | Mean | Range | Mean | Range | Mean | Range | Mean |
| 0-40% | 82 | 0-100% | 72% | 0-80% | 29% | 0-100% | 74% |

The program also maintained an active liaison and follow-up service for the parents. Specific functions included: a) location of appropriate preschool placement for child; b) observations of the child in the new setting and the provision of teacher training where needed; c) regularly scheduled telephone contacts with parents over a year period; d) additional parent training in home or clinic if necessary.

After the target child had been placed in a preschool setting, parents were asked to fulfill a non-binding contractual agreement to provide six months of service to the program by training new parents in the same observational and child management skills that they had mastered.

## General Observation Procedures

Data on former RIP clients and class peers were taken in two different school settings. The first school setting was designated as Group Academic Instruction. Here, the teacher was presenting a lesson to the entire class and thus the behavioral demands on all children were theoretically the same. Observers collected data in the setting for three 30-minute sessions. Data were also collected during Unstructured Recess or Gym periods for each class. Again, three 30-minute samples were taken. In all cases, the total number of observations for an individual class was completed within a three-week interval. Also, observations on former clients were made in the home setting for three 30-minute sessions. These sessions were scheduled across 3-4 week periods during the time immediately preceding or following the evening meal. Parents were asked to instruct all family members to be at home at this time, not to turn on the television, not to make any phone calls during the sessions, and to limit the length of incoming calls.

## Behaviors Observed in School

Adult (teacher, aide, student-teachers) and child behaviors recorded in each school setting are presented below:

### Group Academic Instruction:

A) Adult Command, Demand, Request - this general category includes all non-instructional commands, demands, or requests made by an adult to one of the children under observation. Non-instructional verbal behaviors provide a child with the message to engage in some specific behavior (sit down, get out books), or cease some specific behavior (stop talking, no more running). Instructional commands, demands, requests, on the other hand, solicit some specific information from a child (e.g., "Tell me what 2 and 2 is").

B) Repeated Command, Demand, Request - this general category includes all non-instructional commands, demands, or requests that are identical to original verbal behaviors that did not result in child compliance.

C) Positive Social Reinforcement - this general category refers to positive verbal and gestural behaviors on the part of adults contingent upon compliance to a command, demand, or request or contingent upon general on-task behaviors. Verbal behaviors may include statements such as: "Good, everyone is quiet," "Good Tim, you're working very hard," "I like the way everyone is listening." Gestural behaviors would include pats on the head or back, hugs, etc. As is clear from the examples, Positive Social Reinforcement can be events delivered to a group (of which the focal child is a member) or to a child who is currently being observed.

D) Negative Feedback - this general category refers to negative verbal behaviors on the part of adults contingent upon non-compliance or off-task behavior. Verbal behaviors may include such comments as "If you don't sit down you're going to the principal," "You people have just lost recess," "What's wrong with you!," "Tim, how many times do I have to tell you." Again, comments can be directed to a group of children in which the focal child is a member or to the specific youngster.

E) Compliance to Adult Command, Demand, or Request - this general category of child behavior represents timely (within 5 sec of adult behavior) compliance which may include beginning some new activity (walking to front of class) or stopping some ongoing activity (stops talking).

F) Non-compliance to Adult Command, Demand, or Request - this general category of child behavior represents a continuation of behavior that the adult has requested, demanded, or commanded to be altered. These behaviors may also include direct refusals such as, "I don't want to," "No," or "You can't make me."

G) On-task - this general category of child behavior refers to a wide variety of appropriate school-related behaviors that generally reflect a physical and/or visual orientation to academic materials or instructions. Examples would include: looking at an adult who is providing information or giving instructions; looking at other children in a group who are talking about some academic-related topic; visual orientation toward blackboard or reading material that is the current topic of concern in the class; physical manipulation of objects necessary for completing some task (e.g., coloring, cutting with scissors, writing in a workbook).

H) Off-task - this general category of child behavior refers to a wide variety of inappropriate child responses that do not lead to the completion of academic tasks. Example behaviors would include: looking around the room when seat-work is to be done; talking to class peers when such activity is not sanctioned; getting out of one's seat without permission; interrupting (verbally or physically) other children who are working; looking at other than instructional stimuli of concern (e.g., reading comic books); not having basic materials ready for work (e.g., no pencils, paper, no homework).

Unstructured Recess or Gym:

A) Positive Social Behavior - this general category of interaction includes both motor-gestural and vocal-verbal behaviors. Specific motor-gestural behaviors include: sharing (passing back and forth) play or academic materials; using the same play object or material (sitting on a teeter-totter), holding hands; pats on the head or back; hugs; hand slaps. Specific vocal-verbal behaviors include positive exclamations ("Nice hit," "Way to go"); praising physical appearance or attire ("That's a pretty coat"); questions ("Where's the bat?" "Do you have the time?"). All other conversation between children that does not qualify as Negative Social Behavior.

B) Negative Social Behavior - this general category of interaction includes both motor-gestural and vocal-verbal behaviors. Specific motor-gestural behaviors include: hitting with hand or object; pushing to ground; kicking; stealing or taking away play objects or private items (watch); destroying a construction of another child (as a block tower); biting; throwing objects at another child. Specific vocal-verbal behaviors include: insults to others ("You dummy," "Billy is a Fatty"); negative evaluations of performance ("You can't hit worth beans," "Suzie, you never get it right"); name calling ("Idiot," "Weirdo"); excluding others ("You can't play," "We don't want you here"); refusing to comply with others' requests ("No, it's mine").

C) Appropriate Non-Social - this category of child behavior includes a wide variety of behaviors that are appropriate in recess/ physical education, but that do not involve direct interactions with peers. Examples would be: doing exercises, standing in the outfield while playing baseball, running a race, shooting a basketball, standing in line to throw a ball.

D) Inappropriate Non-Social - this category of child behavior includes a wide variety of behaviors that generally reflect nonparticipation in ongoing activity. Examples of specific behaviors would include: leaving the play area; being placed in "time-out" (asked to sit down, to leave an activity); engaging in some activity that is not currently sanctioned (throwing a ball during an exercise period).

Behaviors Observed in Home

A) Command, Demand, Request - any command-like statement in which a child or children are given a message to engage in some specific behavior (come here, sit down, give me that) or cease some specific behavior (stop fighting, no playing in the house, you to stop it now). Commands, demands, and requests can be directed toward the target child alone or to the target child and his sibling(s) collectively.

B) Positive Social Reinforcement - this general category refers to positive verbal and gestural behaviors on the part of adults contingent upon compliance to a request, demand, or command or contingent upon general appropriate behavior. Verbal behaviors may include statements such as: "Good, you're sitting quietly," "Good Tim, you set the table," "I like the way you both are playing." Gestural behaviors would include pats on the head or back, hugs, etc. As is clear from the examples, Positive Social Reinforcement can be events delivered to the target child or to this child and his sibling(s).

C) Negative Feedback - this general category refers to negative verbal behaviors on the part of adults contingent upon noncompliance or inappropriate behavior. Verbal behaviors may include such comments as "If you don't sit down you're going to bed," "You two can't watch t.v. now," "What's wrong with you!," "Tim, how many times do I have to tell you." Again, comments can be directed to the target and sibling(s) or to the target child alone.

D) Repeated Command, Demand, Request - this general category includes all commands or requests made by an adult that are identical to original commands or requests not complied with. Sample commands would include: "I told you kids to sit down," "I'm telling you for the last time to be quiet," "Steve, sit down, now!"

E) Compliance to Adult Demand, Command, or Requests - this general category of child behavior represents timely (within 5 sec. of adult behavior) compliance which may include beginning some new activity (walking into the kitchen) or stopping some ongoing activity (stops talking).

F) Non-Compliance to Adult Demand, Command, or Request - this general category of child behavior represents a continuation of behavior that the adult has requested, demanded, or commanded to be altered. These behaviors may also include refusals such as, "I don't want to," "No," or "You can't make me."

G) Positive-Social Behavior - this general category of interaction includes both motor-gestural and vocal-verbal behaviors. Specific motor-gestural behaviors include: Sharing (passing back and forth) play or work-related materials; using the same object or material (playing checkers), holding hands; pats on the head or back; hugs; hand slaps. Specific vocal-verbal behaviors include positive exclamations ("Nice going," "Great"); praising physical appearance or attire ("That's a pretty coat"); questions "Where's the bat," "Do you have the time"). All other general conversation between family members and target child that does not qualify as Negative Social Behavior.

H) Negative Social Behavior - this general category of interaction includes both motor-gestural and vocal-verbal behaviors. Specific motor-gestural behaviors include: Hitting with hand or object; pushing to ground; kicking; stealing or taking away play objects or private items (watch); destroying a construction of another child or adult (as a block tower); biting; throwing objects at another person. Specific vocal-verbal behaviors include: insults to others ("You dummy," "Billy is a Fatty"); negative evaluations of performance ("You can't hit worth beans," "Suzie, you never get it right"); name calling ("Idiot," "Weirdo"); excluding others ("You can't play," "We don't want you here"); refusing to comply with others' requests ("No, it's mine").

I) Appropriate Non-Social - this category of child behavior includes a wide variety of behaviors that are appropriate in the home setting, but that do not involve direct interactions with family members. Examples would be: doing dishes, completing homework, reading books or magazines, playing with a game or toy.

J) Inappropriate Non-Social - this category of child behavior includes a wide variety of behaviors that generally reflect nonparticipation in ongoing activity or breaking obvious rules of conduct. Examples of specific behaviors would include: leaving the area without permission; being placed in "time-out" (asked to sit down, to leave an activity); engaging in some activity that is not currently sanctioned (throwing a ball during the meal).

## Observational Procedures

The following sequence of observation was in effect for each 30-minute school session: during the first minute the former RIP client was observed, followed by the predesignated peer #1 the second minute, the RIP client the third minute, peer #2 the fourth minute, and so on. Thus, for each 30-minute session, 15 minutes of data were collected on the former client and 15 minutes on members of the peer group. All target behaviors were recorded as they occurred within consecutive 10-sec intervals. Interval changes were cued via an audio cassette. As soon as any of the target behaviors occurred, they were recorded, however, only one occurrence of each category could be entered in a 10-sec interval. Using this system it was possible to have intervals scored with incompatible behaviors (e.g., on-task; off-task). Positive and negative interactions were entered on a coding sheet such that it was possible to determine whether a focal subject or another child initiated these behaviors.

During the three 30-minute home observations, the former RIP client was the continual focus of observation. Therefore, only social exchanges in which this child was a participant were recorded. With one exception, all other procedures for collecting data in school were employed during home observations.

## Observer Training and Reliability Assessment

Eight observers were trained over a 3-week period on school and home observation systems. Observers practiced on both videotapes and in actual classrooms (not used in the study). Each observer was given an observational manual to read along with specific feedback on scoring behavior categories. Prior to conducting any observations on former clients, each observer had to reach a level of 90% agreement with another rater on three 30-minute sessions. Agreement was calculated on an interval basis for each category of behavior. For example, if during one 10-sec interval observer A recorded "On-task," "Off-task," and "Positive Social Reinforcement" and observer B recorded "On-task," and "Off task" only, then this interval would be scored as having two instances of agreement and one instance of disagreement. Agreement percentage was then calculated for each behavior category by dividing the total number of agreement instances by that number plus the total number of disagreement instances and multiplying by 100. On 20% of all 30-minute observation sessions observer agreement was assessed.

### Problem Behavior Checklist

In school, the former clients' primary teacher completed a modified version of the Walker Problem Checklist (1970) for these youngsters and each of the four classroom peers. The checklist, which contains 50 problem statements, calls for the rater to determine whether each statement is or is not applicable to the child in question. Nine new items were interspersed throughout the inventory. Each item represented some index of academic problems. For example, retention in grades, referral for specialized testing, assignment to a special education class, and a failing grade in an academic subject, were assessed.

In the home setting, one parent, usually the mother, completed the modified Walker checklist.

## Results

### Observer Agreement

Table 3 depicts the ranges and mean percent agreement for each behavior category assessed.

### Adult Behaviors in School

Adult behaviors directed toward the former RIP clients and class peers showed no evidence of differential attention. Specifically, 52%

### TABLE 3

### RANGE AND MEAN PERCENTAGE OF OBSERVER AGREEMENT FOR EACH BEHAVIOR CATEGORY (INCLUDES HOME AND SCHOOL DATA)

| Behavior Category | Range of Agreement Percentage | Mean Agreement Percentage |
|---|---|---|
| Adult Command, Demand, Request | 82-100 | 96 |
| Repeated Command, Demand, Request | 75-100 | 93 |
| Positive Social Reinforcement | 82-100 | 92 |
| Negative Feedback | 75-100 | 90 |
| Compliance to Adult Command, Demand, Request | 83-100 | 94 |
| Non-Compliance to adult Command, Demand, Request | 85-100 | 97 |
| On-task | 80-100 | 90 |
| Off-task | 77-100 | 95 |
| Positive Social Behavior | 72-100 | 92 |
| Negative Social Behavior | 65-100 | 93 |
| Appropriate Non-Social | 68-100 | 97 |
| Inappropriate Non-Social | 79-100 | 96 |

of the instances of commands, demands, and requests were directed at former clients with the remainder aimed at peers. Given the occurrence of child non-compliance there was a .10 probability that adults would direct another identical request to former clients and a .12 probability of this occurrence for class peers. Instances of Positive Social Reinforcement rarely occurred. Adults reinforced former client compliance

4% of the time and peer compliance 5% of the time. On-task behavior by former clients and peers was reinforced on the average, 2 and 1% of the time respectively. Occurrences of Negative Feedback also were observed infrequently. Given an episode of child non-compliance, adults gave former clients and peers Negative Feedback 12 and 14% of the time, respectively. Given an incidence of off-task behavior by former clients or peers, Negative Feedback was provided 2 and 1% of the time, respectively.

## Former Clients' and Peers' Behaviors in School

During Group Academic Instruction the former RIP clients and classroom peers maintained a high level of compliance. For the former clients, compliance occurred, on the average, following 89% of the Commands, Demands, or Requests, with a range across the 40 children of 60-100%. Averaged data for classroom peers showed that 87% of Commands, Demands, or Requests were met with compliance, ranging from 53-100%. Within each classroom there was remarkable homogeneity in compliance response patterns. Specifically, the level of compliance percentages ranged within classrooms, on the average, less than 12%.

An examination of on-task behavior levels during Group Academic Instruction also showed a close correspondence between former RIP clients and class peers. The former RIP clients were observed to be on-task during an average of 86% of the recording intervals, ranging from 69-100%. The classroom peers were observed to be on-task during 87% of the recording intervals, ranging from 52-100%. As with compliant behavior, there was minimal variability in children's on-task behavior within each classroom. For each class studied, the average level of on-task behavior varied less than 15%.

When the children were observed during unstructured free play or gym, both former RIP clients and peers consistently engaged in behavior appropriate to this setting. Former RIP clients and peers averaged 90 and 93% of the recording intervals engaged in appropriate behavior, respectively. Appropriate behavior levels ranged from 80-100% for both groups of children.

The positive and negative interaction patterns of former RIP clients and class peers are depicted in Table 4.

TABLE 4

Range and mean percent of intervals in which former RIP clients and classroom peers engaged in positive and negative social initiations; and, the range and mean percent of intervals in which positive and negative social initiations were received by former RIP clients and classroom peers.

| | Behaviors Initiated | | Behaviors Received | |
|---|---|---|---|---|
| | Positive Social | Negative | Positive Social | Negative Social |
| Former RIP Clients | 14-65% | 0-12% | 4-22% | 0-5% |
| | $\bar{x}$ = 32% | $\bar{x}$ = 2% | $\bar{x}$ = 18% | $\bar{x}$ = 1.5% |
| Classroom Peers | 1 - 62% | 0-15% | 0-38% | 0-8% |
| | $\bar{x}$ = 31% | $\bar{x}$ = 2% | $\bar{x}$ = 20% | $\bar{x}$ = 2% |

The results of t-test comparing both groups of children on each of the behavior categories observed in school revealed no significant differences.

## Demographic Variables Affecting Posttreatment Behavior in School

A variety of statistical procedures were used to assess the relationship between demographic characteristics and posttreatment measures. For example, multiple linear regression (Kerlinger & Pedhazur, 1973) was used initially to investigate whether any of the following variables were predictive of school performance on any of the child behavior categories: sex of client, race of client, birth order, number of siblings, percent attendance during scheduled clinic sessions, mother's age, family intactness (presence of mother and father in home), family income level, mothers' educational level, years away from the program, age treatment began, rapidity with which child met initial behavioral criteria in GT, and rapidity with which mother met initial behavioral criteria in GT. Each of the above listed items was treated as an independent variable in regression equations in which the dependent variable was comprised of one of the child behavior categories. The only independent variable or demographic characteristic that predicted outcome measures was age treatment began. Specifically, this variable was related to current levels of compliance, on-task behavior, and positive interaction initiated and received. On each outcome measure, the earlier treatment began the more favorable was the current level of behavior.

The demographic variables were also studied independent of one another, using one-way analysis of variance to study the influence of dichotomous variables (e.g., sex, race, family intactness) and Pearson Product Moment correlation coefficients to examine the influence of continuous variables (e.g., birth order, number of siblings, mother's educational level, years away from the program, etc.) on all possible outcome measures. Once again, the only statistically significant finding was associated with the age treatment began variable. Here, moderate negative correlations were found between age treatment began and positive interaction (-.23, $p < .10$), compliance (-.38, $p < .05$), and on-task behavior (-.26, $p < .10$).

### Parents' Behavior in the Home

With few exceptions, parents of former clients engaged in patterns of interaction with the target child that resembled the management skills that they were taught three to nine years ago. On 25% (range across parents of 18-40%) of the available opportunities these parents provided positive social reinforcement to their children for compliance to a command, demand, or request. It should be noted that this level of feedback for appropriate child behavior was six times that provided in classroom settings. Also, on the few occasions on which noncompliance was noted, no negative feedback or repeated requests were observed. Also, there was no evidence that parents' responded to their children when they engaged in appropriate or inappropriate non-social activity.

### Former Clients' Behaviors in the Home

A level of compliance that closely matched that observed in the classroom setting was found in the home. Here, former clients complied, on the average, with parents' commands, demands, and requests on 82% of the occasions (range across children of 70-97%).

Inappropriate non-social activity by former RIP clients seldom occurred in the home setting. Less than one-half of 1% of the total number of observation intervals was scored as containing an episode of inappropriate nonsocial activity.

Examining the social interactions of former RIP clients in their home settings reveals two major trends. First, over 97% of all interaction episodes were positive in nature (range across children of 85-100%). Second, the positive social exchanges in which these children participated were quite reciprocal. That is, there was an equal percent of interactions initiated by former clients (52%) and social partners (48%).

### Demographic Variables Related to Former Clients' Home Behaviors

In an initial series of analyses, multiple linear regression procedures were used this time to investigate whether any of the demographic characteristics were predictive of former client behavior in the home setting. Each demographic variable was treated as an independent variable in regression equations in which the dependent variable was comprised of one of the child behavior categories (i.e., compliance to parent requests, positive and negative interaction, appropriate and inappropriate non-social activity). Only two demographic variables were found to predict current performance in the home. Specifically, age treatment began was associated with current levels of compliance and positive social interaction. For each of these outcomes, earlier treatment was related to more favorable levels of behavior. The other demographic variable related to child behavior in the home was family intactness, which was associated with the compliance only. Here, intact families tended to have children who were more compliant.

The demographic variables were also studied independent on one another, using one-way analysis of variance to study the influence of dichotomous variables and Pearson Product Moment correlation coefficient to examine the influence of continuous variables on all child behaviors in the home. Age treatment began was highly correlated with child compliance (-.49, p. <.05), positive interaction (-.52, p. <.05), and appropriate non-social behavior (-.62, p. <.05). Intact families had children who were significantly more compliant (F = 4.76, p. <.01).

## Problem Behavior Checklist Data

Data from the teacher- and parent-completed modification of the Walker Problem Behavior Checklist revealed four primary outcomes. First, there was a highly significant positive correlation between teacher- and parent-completed checklists on former RIP clients (.81, p. <.01). An analysis of discrepancies between teacher and parent ratings for individual children produced no consistent disagreement pattern.

Second, the teacher ratings of former RIP clients and their randomly selected class peers were remarkably similar. On the average, teachers identified 8 problem behaviors for former RIP clients (range of 0-40) and for class peers (range of 0-50). A t-test between the groups' ratings by teachers did not approach statistical significance.

Third, none of the former RIP clients had previously been referred for specialized testing or special services because of behavior problems. Several of the children in both groups had experienced academic learning problems (i.e., retained in grade, placement in learning disabilities resource room).

Finally, children's ratings on the checklist were found to correlate significantly with a number of the observational measures. Specifically, there were significant negative correlations between the number of identified problem behaviors (scored by either teacher or parent) and levels of on-task (-.59, $p. < .05$), compliance (-.64, $p. < .05$), and positive interaction in school (-.61, $p. < .05$). In the home setting there were significant negative correlations between problem behaviors identified and compliance (-.48, $p < .05$), positive interaction (-.62, $p. < .05$), and appropriate non-social activity (-.56, $p < .05$).

## Discussion

The results of this long-term follow-up study showed that: a) commands, demands, or requests made by parents were very likely to be followed by former clients' compliance; b) former clients' social interactions in the home were overwhelmingly positive and their non-social behavior was by and large appropriate; c) parent behavior in the home was consistent with the child management skills taught many years ago; d) there were no differences between the compliant, on-task, social interaction and appropriate/inappropriate nonsocial behaviors of former clients and randomly selected class peers; e) there were no differences in teachers' commands, negative feedback, positive social reinforcement, and repeated commands that were directed toward either former clients or randomly selected class peers; f) both teachers' and parents' rating of former clients on the modified Walker Problem Behavior Checklist were highly correlated; g) there were no differences in teachers' rating of former clients and class peers; and h) of all the studied demographic variables only age treatment began and family intactness were related to current levels of behavior.

Those data collected in the former clients' home setting reveal a clear maintenance of treatment effects for both parent and child. High levels of compliant behavior by former clients were maintained on a schedule of positive feedback by parents that closely matched that provided during the Differential Reinforcement II phase of active treatment. The stability of parent and child behavior change is further documented by the lack of correlation between the variable of "years away from the program" and home-based outcomes. The mechanisms responsible for the observed maintenance of parent and child behavior change cannot be specified fully. However, the fact that intact families had children who were significantly more compliant in the home setting is suggestive of a number of social learning explanations. First, intact families may offer the opportunity for more intensive home programming with both mother and father using differential attention procedures. Second, as suggested by Reisinger, Frangia, and Hoffman (1976), fathers' praise of their wives' efforts at oppositional child training has a positive impact on child behavior change. Obviously, in non-intact families this potential source of encouragement for mothers' efforts would not be available. It should also be noted that Strain et al. (1981) have shown previously that intact families in the RIP program have a greater likelihood of completing the entire four-phase treatment than non-intact families.

Observational data collected in the school setting are suggestive of the generalization of child compliance (the initial treatment objective) across settings. Moreover, the social validity of this generalized behavior change is evidenced by the comparability in level of compliance exhibited by former clients and class peers and the similar behavior ratings of these two groups by teachers. Of course, no pretreatment level of school-based compliant behavior by the former clients is available.

Based on Walker Checklist data it is possible to say that throughout their elementary school careers the former clients had not engaged in problem behaviors that were of such a concern to cause them to be referred for specialized testing or services. While other reports of non-programmed generalization of appropriate behavior are not uncommon (e.g., Cooke & Apolloni, 1976; Forehand, Sturgis, McMahon, Aguar, Green, Wells, & Breiner, 1979; Kifer, Lewis, Greene, & Phillips, 1974), the present results are unique in two respects. First, levels of appropriate behavior (compliance) in the initial treatment setting and in the school setting are quite comparable. Typically, some decrement in appropriate behavior is noted under generalization assessment conditions. Second, it has been noted that generalization effects often "wash-out" over a short period of time (Stokes & Baer, 1977). However, this across-setting effect was shown to persist for three to nine years after active intervention.

Another major set of outcome measures involved the assessment of children's home and school behaviors that have been shown to be associated with globally defined indices of academic and social competence (Strain, 1980). In the home setting, the former clients' social interactions were predominatly positive and their non-social behaviors were similarly appropriate. In summary, the former RIP clients' behavior in the home could be accurately described as compliant, appropriate, and quite positive. This picture of behavior in the home is a profound departure from the tyrannical, oppositional, physically aggressive behavior that characterized these youngsters' home behavior upon referral to the program.

The maintenance of parent and child behavior outcomes in the home setting expands upon Forehands et al's (1979) demonstration of posttreatment changes at 6 and 12 month follow-up points. The school-based data on former clients are, however, in conflict with much of the available follow-up and setting generality data on oppositional child training (e.g., Forehand et al., 1979; Johnson, Bolstad, & Lobitz, 1974; Wahler, 1969; 1975). In these reports, no evidence of positive, across-setting behavior change has been documented. A wide array of subject and service delivery differences may account for the divergent findings. First, the children referred to the RIP program were, as a group, younger than those youngsters treated in earlier efforts. The influence of the age variable is clearly documented by the relationship found between age treatment began and numerous outcome measures. Exactly how the variable of age may mediate long-term outcomes is unknown. However, a logical assumption is that deviant behavior patterns become more resistant to immediate and long-term change when they have occurred over an increasing number of years (Achenbach, 1975; Strain et al, 1981).

An obvious procedural difference between oppositional child training in the RIP system and that used by other investigators is the training agent. In the RIP system only experienced parents were used to train child management skills. In all other reported efforts, professionals or professionals-in-training were responsible for training the parent. The use of parents as trainers may enhance long-term child behavior change for the following reasons. For example, one might logically conclude that the requirement of training others, when combined with one's own training in differential reinforcement procedures would lead to greater conceptual understanding and clinical skills than participating as the focus of training alone. Each of the mothers in this follow-up group had, to varying degrees, been responsible for the instruction of their peers in the treatment paradigm. Also, since these parents generally were successful in training others, they might be more inclined than "non-trainer" parents to influence the behavior of school personnel toward their children (i.e., to encourage the use of behavioral techniques). While no systematic follow-up data are available, many follow-up contacts with parents have indicated that they often suggested to school personnel that differential reinforcement procedures might be used if and when any problem behaviors occurred (Timm, 1981).

In summary, the results of this follow-up study indicate that oppositional child training, in which parents are used as intervention agents and instructors of other parents, may result in long-term changes in the appropriate behavior repertoire of preschool children with severe behavior problems. Moreover, the present data indicate that long-term outcomes are enhanced the earlier treat-is begun and that intact families are more likely than non-intact families to maintain treatment gains.

## References

Achenbach, T. M. The historical context of treatment for delinquent and maladjusted children: Past, present, future. Behavioral Disorders, 1975, 2, 13-14.

Allen, K. E., & Harris, F. R. Elminating a child's excessive scratching by training the mother in reinforcement procedures. In A. M. Graziano (Ed.), Behavior therapy with children, Chicago: Aldine, 1971.

Bernal, M. E. Behavioral feedback in the modification of brat behaviors. Journal of Nervous and Mental Disorders, 1969, 148, 375-385.

Cooke, T. P., & Apolloni, T. Developing positive social-emotional behaviors: A study of training and generalization effects. Journal of Applied Behavior Analysis, 1976, 9, 65-78.

Forehand, R., & Atkeson, B. M. Generality of treatment effects with parents as therapists: A review of assessment and implementation procedures. Behavior Therapy, 1977, 8, 575-593.

Forehand, R., Sturgis, E. T., McMahon, R. J., Aguar, D., Green, K., Wells, K. C., & Breiner, J. Parent behavioral training to modify child noncompliance: Treatment generalization across time and from home to school. Behavior Modification, 1979, 3, 3-25.

Gold Award: A parent-implemented early intervention program for preschool children. Hospital and Community Psychiatry, 1976, 27, 728-731.

Hill, A. D., & Strain, P. S. The effects of teacher-delivered social reinforcement on the task persistent behavior of educable mentally retarded children. Psychology in the Schools, 1977, 14, 207-212.

Johnson, M. R., & Green, D. R. Effectiveness and durability of written instructions: Parental application of differential attention and time out for undesirable behaviors in children. Unpublished manuscript, University of Notre Dame, 1975.

Johnson, S. M., Bolstad, O. D., & Lobitz, G. K. Generalization and contrast phenomena in behavior modification with children. Paper presented at the Sixth Banff International Conference on Behavior Modification, Calgary, Alberta, Canada, 1974.

Kerlinger, F. N., & Pedhazur, E. J. *Multiple regression in behavioral research*. New York: Holt, Rinehart, & Winston, 1973.

Kifer, R. E., Lewis, M. A., Green, D. R, & Phillips, E. I. Training predelinquent youths and their parents to negotiate conflict situations. *Journal of Applied Behavior Analysis*, 1974, *7*, 357-364.

Mathis, H. I. Training a "disturbed" boy using the mother as a therapist: A case study. *Behavior Therapy*, 1971, *2*, 233-239.

O'Dell, S. Training parents in behavior modification: A refiew. *Psychological Bulletin*, 1974, *81*, 418-433.

Ora, J. P. Involvement and training of parents and citizen-workers in early education for the handicapped. In *Not all little wagons are red*. Reston, Virginia: Council for Exceptional Children, 1972.

Patterson, G. R. Retraining of aggressive boys by their parents: Review of recent literature and follow-up evaluation. *Canadian Psychiatric Association Journal*, 1974a, *19*, 142-158.

Patterson, G. R. Interventions for boys with conduct problems: Multiple settings, treatments, and criteria. *Journal of Consulting and Clinical Psychology*, 1974b, *42*, 471-481.

Patterson, G. R., & Fleishman, M. J. Maintenance of treatment effects: Some considerations concerning family systems and follow-up data. *Behavior Therapy*, 1979, *10*, 168-185.

Reisinger, J. J., Frangia, G. W., & Hoffman, E. H. Toddler management training: Generalization and marital status. Journal of Behavior Therapy and Experimental Psychiatry, 1976, 7, 335-340.

Rimm, R. C., Vernon, J. C., & Wise, M. J. Training parents of behaviorally disordered children in groups: A three years' program evaluation. Behavior Therapy, 1975, 6, 378-387.

Snyder, J., Sullivan, W., & Manning, D. Industrial engineering participation in a early education program. Tennessee Engineer, 1974, 1, 21-23.

Stokes, T. F., & Baer, D. M. An implicit technology of generalization. Journal of Applied Behavior Analysis, 1977, 10, 349-367.

Strain, P. S. Assessment and identification of treatment targets for mainstreamed behaviorally disordered children. Paper presented at the Conference on Severe Behavior Disorders, Tempe, Arizona, November, 1980.

Strain, P. S., & Ezzell, D. The sequence and distribution of behaviorally disordered adolescents' disruptive/inappropriate behaviors: An observational study in a residential setting. Behavior Modification, 1978, 2, 403-425.

Strain, P. S., Young, C. C., & Horowitz, J. Generalized behavior change during oppositional child training: An examination of child and family demographic variables. Behavior Modification, 1981, 5, 15-26.

Wahler, R. C. Some structural aspects of deviant child behavior. Journal of Applied Behavior Analysis, 1975, 8, 27-42.

Wahler, R. G. Setting generality: Some specific and general effects of child behavior therapy. Journal of Applied Behavior Analysis, 1969, 2, 239-246.

Wahler, R. G., Winkel, G. H., Peterson, R. F., & Morrison, D. C. Mothers as behavior therapists for their own children. *Behavior Research and Therapy*, 1965, *3*, 113-124.

Walker, H. M. *The Walker Problem Behavior Identification Checklist. Test and Manual*. Los Angeles: Western Psychological Service, Inc., 1970.

# APPENDIX

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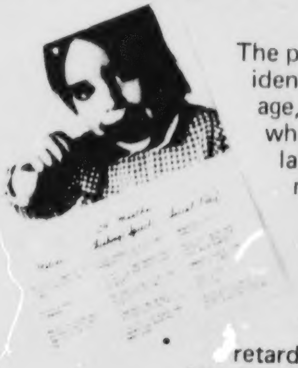


The purpose of the **Child-Find Program** is to identify all children, from birth to 21 years of age, who have any handicapping condition whatsoever—physical, emotional, speech, sight, language, hearing, learning disabilities or mental retardation.

In recent years almost 10% of the children served by public schools were verified as handicapped. Learning problems and disabilities are the most common, followed by speech impairments and mental retardation. Physical handicaps account for only 1%. Behavior problems in young children occur frequently, and parents should be aware that these can be as limiting as any others.

Despite the mandate of the Child-Find laws, it is clear that most handicapped children are not discovered until they start school. In some counties as few as 2% of preschool handicapped children are currently being identified by school systems.

*The State Department of Education is required to evaluate these children and to offer appropriate services depending on the preschoolers' ages.* It makes no difference how mild or severe the problem is. If it could interfere with the child's ability to learn, appropriate educational services must be provided.

The law further states that these services must be provided in as normal a learning environment as possible, so that the child is not isolated from the mainstream of educational life. And, these services must be provided *at no cost to the parent.*

# CHILD CHECK MANUAL

The **MANUAL** is for the use of: • **Child-Find** Organizers • Workshop Leaders • **CHILD CHECK** Campaign Volunteers.

It tells how to: • Conduct a workshop for parents • Organize a Campaign • Form a Task Force • Enlist media cooperation • Win community support using the **CHILD CHECK** audio-visual presentations.

# How To Order:

BY MAIL:

**LAWREN PRODUCTIONS, INC.**
P.O. BOX 666,
MENDOCINO, CALIFORNIA 95460

BY PHONE:
**(707) 937-0536**

Send the complete CHILD CHECK package on these terms:

☐ Purchase ☐ Rental ☐ Preview*

(Please check one):

☐ The 35 mm Slide Tape Show
☐ The 16 mm Film

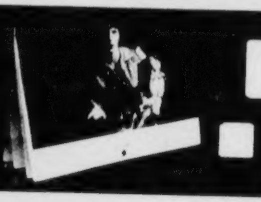
The package will contain two copies of the CHILD CHECK DIARY as well as one copy of the CHILD CHECK MANUAL.

| **PRICES:** | | |
|---|---|---|
| **PURCHASE:** | **FILM**<br>(Color, 24 Minutes)<br>$340.00 | **SLIDE TAPE SHOW**<br>(2 Carousels, 240 slides)<br>$160.00 |
| **RENTAL:** $40 for one week, for either film or slide tape show. | | |
| **PREVIEW:** $10(*) for either film or slide tape show. | | |

Shipping cost is added to all shipments. On rentals and previews, customer pays return postage and insurance.

(*) Regional Media Centers with budgets and procedures for purchase evaluation may request free preview privilege.

## Special Offer:



## SHIPPING INSTRUCTIONS

ORDER NUMBER:__________

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(If you use a P.O. Box, please show street also for possible UPS forwarding.)

CITY:__________ STATE:__________ ZIP:__________

ORDERED BY:__________ TITLE:__________ PHONE:__________

# CHILD CHECK AUDIO-VISUAL PRESENTATIONS

**THE BASIC PACKAGE** includes two carousels containing 240 35 mm slides with one audio tape, with signal for automatic slide advance, or one 16 mm sound film; two copies of the CHILD CHECK DIARY; and one copy of the MANUAL. Content of slide tape show and film are identical, 25 minutes, color.

CHILD CHECK
MANUAL
ADAPTED BY
CLIFFORD PROBST
FROM THE AUTHORS
BARBARA DEVANEY, MSW
& P.DAVID KURTZ, Ph.D.
Child Check Diary

## AUDIENCES

*Show the slide tape or film to:*

PARENTS
- CLUBS
- CHURCHES
- ASSOCIATIONS
- TELEVISION PROGRAMS*
- CLINICS
- HEALTH CENTERS

STUDENTS/TEACHERS
- WORKSHOPS
- DAY CARE CENTERS
- HEAD START
- PTA GROUPS
- PRESCHOOL
- CHILDBIRTH PREPARATION

GENERAL AUDIENCES
- PARENTING
- PSYCHOLOGY
- FAMILY LIFE EDUCATION
- CHILD DEVELOPMENT
- SPECIAL EDUCATION

*CONTENTS:*

✓
✓
✓
✓
✓
✓
✓

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* Television broadcast is encouraged; however, written permission from the distributor is required for telecast or any duplication of material.

Public schools are required to find and to e[illegible]ate children with handicaps—from birth to age 21—with[illegible] cost to the parents, and to provide appropriate education beginning in preschool years. – P.L. 94-142

## FOR AN EFFECTIVE CHILD-FIND REPORT, PARENTS MUST BE ENLISTED

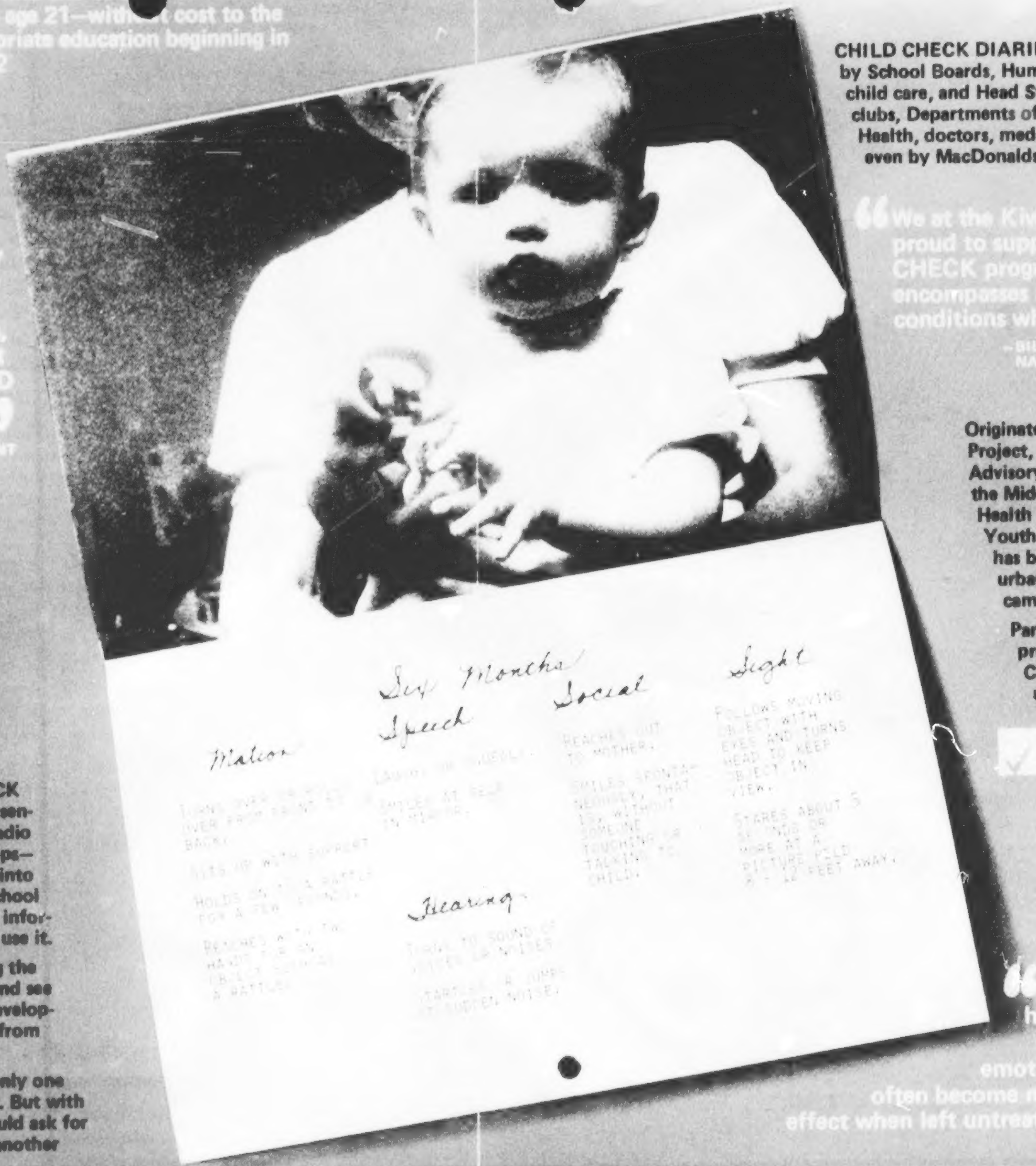
> “Parents can be the best early detection system: they have the opportunity to observe their child over long periods, and they have an investment in the child's welfare. CHILD CHECK shows them how.”
>
> –PHIL STRAIN, PH. D.
> TENNESSEE DEPARTMENT
> OF MENTAL HEALTH

# CHILD CHECK DIARY

The whole thrust of a CHILD CHECK campaign—the film or slide-tape presentations; newspaper, television and radio features; speakers, posters, workshops—is to put a CHILD CHECK DIARY into the hands of every parent of a preschool infant or child, and provide enough information and motivation for them to use it.

The objective is to get them to hang the diary on the child's bedroom wall and see if the child masters the skills and developments expected at the various ages from 6 months to 5 years.

The parent is told not to worry if only one skill is missing or late in developing. But with two or more delays, the parent should ask for an assessment by the school or by another locally designated agency.



Six Months

Motor

TURNS OVER [illegible] OVER FROM [illegible] BACK.

SITS UP WITH SUPPORT.

HOLDS ON TO A RATTLE FOR A FEW SECONDS.

REACHES WITH [illegible] HAND FOR AN OBJECT SUCH AS A RATTLE.

Speech

LAUGHS OR SQUEALS.

SMILES AT SELF IN MIRROR.

Hearing

TURNS TO SOUND OF VOICES OR NOISES.

STARTLES OR JUMPS AT SUDDEN NOISE.

Social

REACHES OUT TO MOTHER.

SMILES SPONTANEOUSLY, THAT IS, WITHOUT SOMEONE TOUCHING OR TALKING TO CHILD.

Sight

FOLLOWS MOVING OBJECT WITH EYES AND TURNS HEAD TO KEEP OBJECT IN VIEW.

STARES ABOUT 5 SECONDS OR MORE AT A PICTURE HELD 8 - 12 FEET AWAY.

**CHILD CHECK DIARIES** have been distributed by School Boards, Human Resources offices, PTA, child care, and Head Start groups, churches, civic clubs, Departments of Public Health and Mental Health, doctors, medical centers, and clinics—even by MacDonalds and Burger Kings.

> “We at the Kiwanis Club were proud to support the CHILD CHECK program because it encompasses all handicapping conditions which affect children.”
>
> –BILL PARRISH
> NASHVILLE, TENNESSEE

Originated by the RIP Expansion Project, sponsored by the RIP Advisory Committee, Inc., and the Middle Tennessee Mental Health Institute, Children and Youth Services, CHILD CHECK has been tested in rural and urban community awareness campaigns.

Parents who attended group presentations of CHILD CHECK improved their understanding of:

- ☑ The importance of the first five years of a child's development.
- ☑ Benefits of early detection of—and treatment for—a disability.
- ☑ The child's rights under the law.

> “There are a number of handicapping conditions (mental retardation, emotional disturbance), that often become more devastating in their effect when left untreated in preschool years.”
>
> –PHIL STRAIN, PH. D.

AGREEMENT

This Agreement is made at NASHVILLE, TENNESSEE August 8, 1980 [illegible] 1980 between [illegible], [illegible] Avenue, Nashville, TN [illegible], hereinafter called the [illegible], and Film House, Inc., organized and existing under the laws of Tennessee, and hereinafter called the Producer, for the production of [illegible] media presentation as defined according to the following specifications, terms and conditions.

Clause 1. DESCRIPTION

The Producer shall produce and deliver the media production Items #1-3, 5 and 6 of the videotapes production as described in the INVITATION TO SUBMIT BIDS dated June 13, 1980, (Appendix A). (Item 4 as described will be replaced by another data tape.) All running times specified therein are accepted as approximate.

Clause 2. PAYMENT

In considerations for the [illegible] and [illegible], the Client shall pay the Producer the total sum of $3,000.00 as follows:

$1,000.00 on signing of contract.

$1,000.00 on delivery of approved [illegible] for field testing.

$1,000.00 on delivery of masters (approved final version) and multiple dubs.

Clause 3. PRODUCTION SCHEDULE AND APPROVAL

The Producer shall deliver one dub of videotapes not later than September 15, 1980. The client pledges to facilitate beginning of production as early as possible. The Producer will complete amendments, repairs and corrections within reason to satisfy the Client, not later than October 15, 1980. The Client pledges to ask for those amendments, repairs and corrections as early as possible after delivery of first version. The Producer will deliver the final versions of master and multiple dubs not later than October 30, 1980.

The Producer and the Client pledge to cooperate closely on every aspect and through all stages of the production to insure approval of the final products.

Clause 4. SERVICES

The Producer shall provide all services, materials, technical personnel, and equipment necessary for the completion of the productions except as follows: The Client shall provide the use of two (2) video cameras if these are available.

Clause 5. The Producer agrees to perform under this Agreement in accordance with accepted trade standards and ethics, and with the quality of standards of the Producer's work previously exhibited to the Client. The Client agrees that he is satisfied with prior evidence of the professional competence of the Producer.

Clause 6. LIAISON

The Client agrees to appoint one liaison representative who shall have the power to act for the Client, including prompt and final approval of work at all stages, binding upon the Client. The liaison representative shall be readily available to the Producer and shall assume responsibility for conveying the Client's decisions regarding matters of policy and technical content during photographic, videotaping, and sound recording activities.

## Clause 7. PRODUCER IN CHARGE

The Producer agrees to assign Curt Hahn to be the producer in charge of this contract. The Producer also agrees to make available Jan Belcher for consultations, particularly in planning and evaluation stages of the production process.

## Clause 8. CLIENT COOPERATION

The Client agrees to provide the Producer with reasonable assistance in script research, technical and subject matter content specification, identification and preparation of production locations, and provision of human subjects to be used in the production.

Clause 9. ADDITIONAL WORK AND COSTS

The Producer shall make such reasonable changes as the Client may request without penalty. If, in order to comply with additional Client changes, the Producer must depart from the previously approved work and specifications and incur additional expense as a result, the Client shall reimburse the Producer. However, the Producer shall make changes at his own expense if they are the result of his own unsatisfactory work or a material departure from specifications.

Clause 10. RIGHTS

The Client has the rights to all tangible materials produced under this contract, and may use them as he deems necessary.

Clause 11. CREDITS

The Producer has the right to include credit or identification of his involvement with the production in [illegible] credits section of the videotape [illegible].

Clause 12. COPIES

[illegible] shall supply one (1) master [illegible] one (1) 3/4" cassette, [illegible] (1) [illegible] cassette and two (2) ½" [illegible] copies of all production items specified in Clause 1 of this Agreement.

### Clause 14. INSURANCE

The Producer assures provision of insurance coverage for bodily injury and property damage claims incurred as a result of activities related to this production at a level not less than $300,000.00. The Producer agrees to take reasonable precautions against damage or loss involving equipment owned or supplied by the Client, but cannot be held responsible for damage or loss to said equipment.

### Clause 15. TIMELY PAYMENT

A. In the event the Client fails to make timely payments, the Producer shall have the right to suspend production until due payment is received. However the Producer shall resume immediately on receipt of such payment plus service fee not to exceed 10 percent per annum on balance due, plus such collection costs, arbitration and legal fees as have been expended.

B. The Producer is required to complete and release those productions and related materials immediately after receipt of all due payments. The Producer shall have a lien on all prints and other tangible property related to this Agreement until all payments are made by the Client to the Producer.

## Clause 15. DELAY AND TERMINATION

A. Delay by the Producer in production of this contract due to war, fire, embargoes, strikes, laws, lockouts, government orders, industrial actions, illness, accidents, laboratory failures, public disaster, Acts of God or other cause beyond his control shall not give rise to any claim against the Producer.

B. In the event of unreasonable delay due to the above causes, the Client shall be entitled to terminate this Agreement subject to payment of all costs incurred and commitments made by the Producer to the date of termination, in lieu of overhead, plus 10 percent of such costs. Where such total amount is exceeded by the amounts already paid by the Client hereunder, the difference shall be immediately reimbursed by the Producer to the Client.

C. If at any time the Client wishes to abandon production of this contract for any reason whatsoever, the Client may do so by giving written notice to the Producer and paying the Producer only the amount of profit which would have been due had the contract been completed and for costs of production incurred or committed by the Producer prior to date of termination. Immediately on receipt of termination notice, the Producer shall acknowledge and agree to termination, end all work, commitments and expenses in the best financial interests of the Client, and submit to the Client within 30 days of receipt of termination notice a detailed and final claim.

In witness whereof the parties have executed this Agreement this eighth day of August 1980.

CLIENT RIP Expansion Project
SIGNED BY Barbara J. Fickel
TITLE Training Coordinator - Component C
PRODUCER Curt Hahn
SIGNED BY Judith A. Belcher
TITLE Vice President, Film House, Inc
WITNESSED BY Charles E. Howard Jr.

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Department of Psychology
The University of Tennessee
Knoxville, TN 37919

## Opening Statement

As you may remember, we are conducting this survey of about 60 parents in your community for the RIP Expansion Project, which offers services for parents and their preschool children with behavior problems and other handicaps. We want to find out how different parents view the growth and development of normal and handicapped children. We also want to know what parents think the role of our community is in serving handicapped children. This information will help us to understand children better and plan for the special needs of parents.

The survey takes about 30 minutes. I'll read the questions to you from this form, and then I'll put down your answers. You can read the questions along with me. Keep in mind that the questions are seeking your ideas and opinions about children and some general information about your family. No one will know how you answer these questions except you, me and the project staff. Your answers will be grouped with those of other parents in your town. You may refuse to answer any of the questions and you may stop the survey at any time.

Your cooperation in this survey is most valuable because it helps us understand children. The project would not be possible without the help of parents like you.

Do you have any questions?

Before we begin the survey I will read the Informed Consent Form which I will ask you to sign. This form will be kept separate from your answers and will be the only place where I will ask you to sign your name. This form is a necessary formality.

# Informed Consent Form

I understand that my participation in this survey is voluntary. I understand that the purpose of the survey is to find out parents' views on the growth and development of normal and handicapped children, what the community can do to help handicapped children, as well as, some general information about my family.

I understand that I can ask any questions I may have and that they will be answered as completely as possible. I understand that my answers and my name will be kept confidential. I understand that I am free to stop this interview at any time.

By signing this form I give my permission for my answers to be used and I agree to participate in this survey.

Date____________________ Signature______________________

HANDICAPS CAN BE PHYSICAL, EMOTIONAL, BEHAVIORAL, SPEECH, HEARING OR LEARNING PROBLEMS, AS WELL AS MENTAL RETARDATION. PLEASE TELL ME AFTER I READ THESE STATEMENTS WHETHER YOU STRONGLY AGREE, AGREE, DISAGREE, STRONGLY DISAGREE OR ARE NOT SURE. THERE ARE NO RIGHT OR WRONG ANSWERS. NOW FOR THE FIRST QUESTION:

| | Strongly Agree | Agree | Disagree | Strongly Disagree | No Su |
|---|---|---|---|---|---|
| 1. Parents are often the last to notice handicaps in their own children. | | | | | |
| 2. Most mentally retarded children cannot learn very much. | | | | | |
| 3. Usually, parents of handicapped children should learn special skills to help with their children's development. | | | | | |
| 4. Most handicapped children would be better off if they lived at home with their families. | | | | | |
| 5. Prayer often helps mentally retarded children become like other children. | | | | | |
| 6. Parents who think their child is handicapped should seek help immediately. | | | | | |
| 7. Mentally retarded children usually catch up with other children after a few years in school. | | | | | |
| 8. Handicapped children should be sent to school at a younger age than other children. | | | | | |
| 9. The family doctor should be the main person responsible for noticing handicaps in children. | | | | | |
| 10. It is hard to live with most handicapped children. | | | | | |
| 11. Education is not as important for a handicapped child as it is for a normal child. | | | | | |

| | Strongly Agree | Agree | Disagree | Strongly Disagree | Not Sure |
|---|---|---|---|---|---|
| 12. Most handicapped children should be separated from normal children. | | | | | |
| 13. Normal children become like handicapped children if they play with them too much. | | | | | |
| 14. We would be better off if most handicapped children were sent off to a special home. | | | | | |
| 15. A handicapped child is a God-given burden whom parents should not try to change. | | | | | |

IN THE NEXT SECTION YOU CAN GIVE YOUR OPINIONS ON WHAT CHILDREN CAN DO AT CERTAIN AGES. FOR EACH QUESTION I READ TO YOU, TELL ME WHETHER YOU THINK ALMOST ALL, MOST, SOME OR VERY FEW CHILDREN CAN DO WHAT I ASK AT THAT AGE. IF YOU DO NOT WANT TO PICK ONE OF THESE CHOICES YOU MAY ANSWER "NOT SURE." I WILL START WITH QUESTIONS ON THREE AND FOUR MONTH OLD CHILDREN.

| | Almost All | Most | Some | Very Few | Not sure |
|---|---|---|---|---|---|
| 16. Do three month old babies smile without being touched or talked to? | | | | | |
| 17. Can three month old babies sit without support? | | | | | |
| 18. Can four month olds hold a rattle for a few seconds? | | | | | |

OKAY, NOW FOR SOME QUESTIONS ON TWELVE MONTH OLDS.

| | Almost All | Most | Some | Very Few | Not sure |
|---|---|---|---|---|---|
| 19. Can 12 month old children play pat-a-cake, "so big," or wave bye-bye? | | | | | |
| 20. Can 12 month old children walk up stairs without holding on to anything? | | | | | |
| 21. Can 12 month old children copy sounds such as mmm or gaa? | | | | | |

|  | Almost All | Most | Some | Very Few | Not sure |
|---|---|---|---|---|---|
| 22. Can 12 month old children use a spoon to eat without spilling much? |  |  |  |  |  |
| 23. Can 12 month old children pick up small things like raisins using the thumb and one finger? ( NOTE TO INTERVIEWER: DEMONSTRATE BY PICKING UP SMALL ITEM.) |  |  |  |  |  |
| 24. Can 12 month old children say at least 10 words? |  |  |  |  |  |

NOW I WILL ASK YOU SOME QUESTIONS ABOUT 18 MONTH OLDS.

|  | Almost All | Most | Some | Very Few | Not sure |
|---|---|---|---|---|---|
| 25. Can 18 month olds wash and dry their hands well enough that the hands are almost completely dry and have no soap on them? |  |  |  |  |  |
| 26. Can 18 month olds scribble on paper without help when given a pencil? |  |  |  |  |  |
| 7. Can 18 month olds say their irst and last names? |  |  |  |  |  |
| 28. Can 18 month olds follow commands such as "shut the door," or "get your shoes?" |  |  |  |  |  |
| 29. Can 18 month olds drink from a cup with no help without spilling? |  |  |  |  |  |
| 30. Can 18 month olds copy a good traight up and down line? |  |  |  |  |  |

HE NEXT QUESTIONS ARE ON 2½ YEAR OLDS.

|  | Almost All | Most | Some | Very Few | Not sure |
|---|---|---|---|---|---|
| 1. Can 2½ years olds cut with a scissors? |  |  |  |  |  |
| 2. Can 2½ year olds join in ursery rhymes and songs, by singing st of the words? |  |  |  |  |  |

| | Almost All | Most | Some | Very Few | Not sure |
|---|---|---|---|---|---|
| 33. Can 2½ year olds put on some of their own clothing such as shorts, shirts, and sweaters? | | | | | |
| 34. Can 2½ year olds throw a ball overhand to a person? (DEMONSTRATE OVERHAND THROW) | | | | | |
| 35. Can 2½ year olds button up any clothing? | | | | | |
| 36. Can 2½ year olds identify correctly at least three of these colors: red, blue, yellow, green? | | | | | |

THE LAST GROUP ARE THE 4 YEAR OLDS.

| | Almost All | Most | Some | Very Few | Not sure |
|---|---|---|---|---|---|
| 37. Can children of 4 years be expected to go on errands outside the home, such as taking something to a neighbor's house? | | | | | |
| 38. Can children of 4 years understand the meaning of cold, tired, hungry? For example, if asked "What do you do when you're tired?" do they answer "sleep," or "go to bed?" | | | | | |
| 39. Can children of 4 years catch a bounced ball with their hands? | | | | | |
| 40. Can children of 4 years print a few capital letters? | | | | | |
| 41. Can children of 4 years be left with a babysitter or non-family member without getting too upset? | | | | | |
| 42. Can children of 4 years explain what at least 6 objects are used for such as "a knife is used to cut things."? | | | | | |

I AM GOING TO READ SOME STATEMENTS ABOUT PUBLIC SCHOOLS. IF YOU AGREE WITH THE STATEMENT ANSWER "YES," AND IF YOU DISAGREE ANSWER "NO." GO AHEAD AND GUESS EVEN IF YOU ARE NOT POSITIVE ABOUT YOUR ANSWER. IF YOU ARE STILL UNCERTAIN YOU MAY ANSWER "NOT SURE."

| | Yes | No | Not Sure |
|---|---|---|---|
| 43. Public schools are required by law to separate normal from handicapped children. | | | |
| 44. If the public school a handicapped child attends does not have a special program, schools, not parents, are legally responsible to find an appropriate program for the child. | | | |
| 45. Public schools are required by law to let parents know the details of their handicapped child's educational plan. | | | |
| 46. Public schools can legally place children in special education classes without talking to parents about it. | | | |
| 47. Handicapped children have the legal right to a free education at age 4. | | | |
| 48. Local public schools are required by law to look for and enroll handicapped children in school. | | | |
| 49. Parents have a legal right to look at their children's school records. | | | |
| 50. Public schools may legally require parents to pay extra for a handicapped child's education. | | | |

51. Is any member of your immediate family handicapped? Yes____ No______
(If no, skip to question 55.)

52. How many family members are handicapped? ____________________

53. What type(s) of handicaps does (do) the family member(s) have?

____________________________________________

54. What help has (have) this (these) member(s) of your family received? For example, special education, special health care, counseling or social security disability money?

____________________________________________

55. Is anyone outside your family whom you know well handicapped?

Yes_____ No ____ (If no skip to question 57.)

56. What type of handicap does this person have? ____________________

57. If parents discover they have a handicapped child, who do you think they should turn to for help?

____________________________________________________________

58. What people and agencies in your community provide help or services to handicapped children?

____________________________________________________________

ONE OF THE PURPOSES OF THIS SURVEY IS TO FIND OUT SOME GENERAL INFORMATION ABOUT THE FAMILIES IN YOUR COMMUNITY. YOUR ANSWERS TO THESE QUESTIONS WILL BE KEPT STRICTLY CONFIDENTIAL. SOME OF THESE QUESTIONS ARE PERSONAL. IF YOU DO NOT WANT TO ANSWER PLEASE LET ME KNOW.

64. Are you: married, separated, divorced, single, or widowed? (Circle one)

69. Who sees your children if they have health problems?

Name: ____________________ Speciality: ____________________

72. How often do you get together with relatives outside your immediate family who live outside your home?

____________________ Almost every day or daily
____________________ Once or twice per week
____________________ Once or twice per month
____________________ A few times per year or less

73. How often do you get together with friends other than relatives?

____________________ Almost every day or daily
____________________ Once or twice per week
____________________ Once or twice per month
____________________ A few times per year or less

74. Would you estimate your family's average annual income to be:

____________________ Under \$7,000
____________________ \$7,000 - \$9,999
____________________ \$10,000 - \$14,999
____________________ \$15,000 - \$19,999
____________________ \$20,000 or more

101. Parents have the major responsibility for noticing handicaps in their children. Do you
_____strongly agree
_____agree
_____disagree
_____strongly disagree
_____not sure

102. It is important for parents to check their children's development regularly. Do you
_____strongly agree
_____agree
_____disagree
_____strongly disagree
_____not sure

103. Within the past few months have you heard, read, or seen anything new about preschool children? ___Yes ___No _____ Not Sure

104. Within the past few months where have you heard, read, or seen things about preschoolers?

___radio (What program?________________)
___TV (What program?________________)
___Poster(Where?________________)
___Handout, Pamphlet (Where from?________________)
___Doctor(Name________________)
___Church(Name________________)
___Minister(Name________________)
___Newspaper(Name________________)

___Preschool program (Name__________
___Public Agency(Name__________
___Friend
___Relative
___Books, magazines
___Meeting (Sponsor__________
___Other(Specify__________
___Not Sure

105. In the past few months have you heard, or seen things about preschoolers?
___less than usual
___about the same as usual
___more than usual

106. What new things have you learned about preschoolers in the past few months?________________________________________

107. In recent months have you heard or read about a program called CHILD CHECK? ___Yes ___No ___Not Sure (If No or Not Sure, Skip to 110.)

108. What do you think CHILD CHECK is all about?________________________________________

109. Where did you read, see or hear about CHILD CHECK?

___radio(What program?______________)___Preschool program(Name______________

___TV(What program?______________)___Public Agency(Name______________

___Poster(Where?______________)___Friend

___Handout, pamphlet(Where from?______
______________)___Books, magazines

___Doctor(Name______________)___Meeting(Sponsor______________

___Church(Name______________)___Other(Specify______________

___Minister(Name______________)___Not Sure

___Newspaper(Name______________)___At work(Where?______________

110. Have you heard, seen or read about a CHILD CHECK Diary? ___Yes ___No ___Not Sure (If No or Not Sure, skip to 119).

111. What is a CHILD CHECK Diary?______________
______________

112. Where did you read, see or hear about a CHILD CHECK Diary?

__radio(What program?______________)___Friend

__TV(What program?______________)___Relative

_Newspaper(Name______________)___Meeting(Sponsor______________

Poster(Where______________)___Preschool program(Name______________

_Handout, pamphlet (Where______
______________)___Public Agency(Name______________

Doctor(Name______________)___Other(Specify______________

Church(Name______________)___Not Sure

Minister(Name______________)___At work (Where?______________

. Did you ever receive a CHILD CHECK Diary? ___Yes ___No ___Not Sure
(If No or Not Sure, skip to 119).

4. From whom or where did you receive a CHILD CHECK Diary?

___Doctor(Name_________________)
___Church(Name_________________)
___Minister(Name_______________)
___School System
___Mental Health Center
___At work
___Public Agency(Specify________________)
___Friend
___Relative
___ Meeting (Sponsor________________)
___Health Department
___Other(Specify________________________)

115. How many times have you used the CHILD CHECK Diary to check your child's development? ___0 ___1 ___2 ___3 ___4 or more

116. Where is your CHILD CHECK Diary now? (Specify room________________)

117. What should you do if you find your child can't do many of the things listed under his or her age on the CHILD CHECK Diary?______________
_____________________________________________________________

118. Most parents of preschoolers should use the CHILD CHECK Diary to check how well their children are developing. Do you
___strongly agree
___agree
___disagree
___strongly disagree
___not sure

119. Did you ever attend the CHILD CHECK group instruction? __Yes __No __Not Sure (If No or Not Sure, skip to # 122).

120. What is the CHILD CHECK group instruction all about?__________________
_____________________________________________________________

121. It is important for parents of preschoolers to attend the CHILD CHECK group instruction. Do you
___strongly agree
___agree
___disagree
___strongly disagree
___not sure

122. Did you see part of the CHILD CHECK slide tape show on television in late March? _____Yes _____No If yes how did you watch
_____All of the show
_____Half or more
_____Less than half

Thank you for answering these questions. Without your help this project would not have been possible.

**123. Was your child screened in March, 1980 by the Paris Special School District? ___ Yes ______no**

## METRO TELEPHONE SURVEY: OPENING STATEMENT - POST

Hello is this Mr./Mrs_______________? This is_______________ _________ from the RIP Expansion Project. We run preschool programs for children and their parents.

About 8 months ago you answered some questions for us about the growth and development of young children. That information was very helpful in planning service for young children. I would like to ask you a few more questions.

It will take a about 5 minutes. What you tell me will be kept confidential.

Your cooperation in this survey is most valuable because it helps us understand children better. The project would not be possible without the help of parents like you.

Do you have any questions before we begin?

Interviewee Name: Mr/Mrs.______________________________
(Circle one)

Identification Number_____________

[illegible] PROBABLY [illegible] FOR

[illegible] THAT HANDICAPS CAN BE PHYSICAL, [illegible]

[illegible] VISUAL, SPEECH, HEARING OR LEARNING PROBLEMS

OR [illegible] AS MENTAL RETARDATION. PLEASE [illegible] ME AFTER I READ THESE STATEMENTS WHETHER YOU STRONGLY AGREE, AGREE, DISAGREE, STRONGLY DISAGREE OR ARE NOT SURE. THERE ARE NO RIGHT OR WRONG ANSWERS. NOW FOR THE FIRST STATEMENT:

Strongly agree SA
Agree A
Disagree D
Strongly disagree SD

| | SA | A | D | SD | Not Sure |
|---|---|---|---|---|---|
| Parents are often the last to [illegible] their own children. (REPEAT [illegible]) | | | | | |
| [illegible] usually [illegible] | | | | | |
| Most [illegible] children [illegible] after [illegible] years [illegible] | | | | | |
| Handicapped children should be [illegible] and [illegible] other children | | | | | |
| [illegible] should [illegible] the [illegible] for [illegible] handicaps [illegible] | | | | | |

NOW WE'RE GOING TO READ SOME STATEMENTS ABOUT PUBLIC SCHOOLS. IF YOU THINK THE STATEMENT IS TRUE ANSWER "YES," AND IF YOU THINK IT IS FALSE ANSWER "NO." IF YOU ARE UNCERTAIN YOU MAY ANSWER "NOT SURE."

| | Yes | No | Not Sure |
|---|---|---|---|
| 1. Public schools are required by law to separate [illegible] handicapped children. (REPEAT POSSIBLE ANSWERS) | | | |
| 2. If the public school a handicapped [illegible] does not have a special program, schools, [illegible], are legally responsible to [illegible] special program for the child. | | | |

[illegible]

Handicapped [illegible] Selected [illegible]
[illegible] education [illegible]

[illegible] best possible [illegible]
and for [illegible]

Public [illegible]
[illegible]

[illegible] MC.

If parents [illegible] they have a [illegible]
[illegible] they would [illegible]

[illegible]
[illegible] and [illegible]

[illegible]. What are the ages of your children? ____________________

106. Within the past few months have you heard anything about preschoolers from any of the following sources:

(Check those parents says yes to)
__radio, __TV, __handout or pamphlet, __doctor, __church or minister, __day care or preschool, __public agency, __friend or relative, __book or magazine, __meeting, __other ____________________

107. In recent months have you heard about a program called CHILD CHECK?
__Yes, __No, __Not Sure (If No or Not Sure, skip to 110)

108. What do you think CHILD CHECK is all about? ____________________

109. Where did you hear about CHILD CHECK? ____________________

110. Have you heard about the CHILD CHECK Diary? __Yes, __No, __Not Sure
(If No or Not Sure, skip to 1[illegible])

What is a CHILD CHECK Diary? ____________________

[illegible] Where did you hear about the CHILD CHECK [illegible] ____________________

11[illegible]. [illegible] a CHILD CHECK [illegible] __Yes, __No, __Not Sure
(If No or Not Sure, skip to [illegible])

[illegible] where did you [illegible] ____________________

[illegible] have you used [illegible] CHILD CHECK [illegible] your [illegible]
__1 __2 __3 __4 or more

Did you [illegible] attend a CHILD CHECK group instruction meeting?
__Yes, __No, __Not Sure (If No or Not Sure, skip to [illegible])
If yes, where ____________________
What was this CHILD CHECK group instruction all about? ____________________

Can your child do all the items in the Diary for his/her age range?
__Yes, __No, __Not Sure

Do you still have your CHILD CHECK Diary? __Yes, __No, __Not Sure

[illegible]. Has your preschool child received any new professional services since last [illegible]? __Yes, __No

What service is this? ____________________

[illegible]. Ask this question only if parent has heard of CHILD CHECK:
Did learning about CHILD CHECK prompt or encourage you to take any action regarding your preschooler? __Yes, __No

What action did you take? ____________________

examination, it shall be provided at State expense.

After placement in the recommended program, periodic progress reports must be provided parent.

**...But**

If after your handicapped child has been placed in the recommended program and you feel it is not in the best interest of your child, you may request another review by the evaluation team. If you do not agree with the decision made by the team, you should make a request in writing to your local school district superintendent, asking for a due process hearing.

If you disagree with the decision by the hearing officer, then it will be your responsibility to seek legal action through chancery or circuit courts.

If your handicapped child is not being provided any kind of educational program by the local school district, then you should meet with the superintendent of your school district to request an educational program for your child.

If you are not satisfied with the results of this request, then you should contact the **Right to Education Office**, which will arrange to investigate the case.

**...Above All**

Remember that **the responsibility for providing an appropriate educational program for your handicapped child rests with your local school district.**

**For further information or assistance contact:**

***The Right to Education Office***
***State Department of Education***
***Room 104, Cordell Hull Building***
***Nashville, Tennessee 37219***

**Telephone: (615) 741-2851**
**(615) 741-2963**

**Authorization No. 1183**

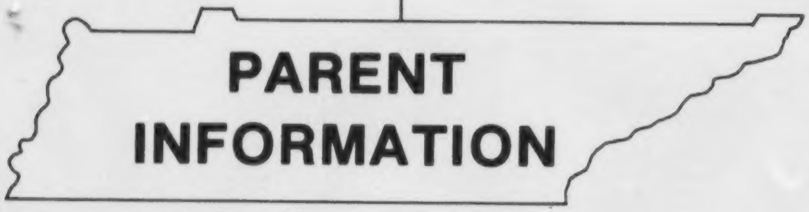
**"This public document was promulgated at an annual cost of $75.00, or $0.0075 per copy, to give parents and professionals an awareness of the rights of parents and responsibilities of educational agencies in the provision of appropriate services for handicapped children."**

020-00004R1
07-80-010M

# EQUAL EDUCATIONAL OPPORTUNITIES FOR ALL

**HANDICAPPED CHILDREN**

**NON-HANDICAPPED CHILDREN**



# PARENT INFORMATION

Reprint
Tennessee Department of Education
Nashville, Tennessee
May, 1979
E. A. Cox, Commissioner

## The Law Now Provides...

Chapter 29, Tenn. Code Annotated, 1972, often referred to as "Mandatory Education of the Handicapped," provides for the education of **all** handicapped persons in Tennessee, ages 4 through 21 (3 through 21 for hearing impaired persons).

**It makes no difference where these persons are or how severe the handicap is.**

The local school district in which the handicapped person resides has the responsibility for providing or securing **appropriate** special education services to meet the needs of each handicapped person.

## ...For All Handicaps

If your child is;

- Mentally Retarded (EMR, TMR, Profound)
- Speech or Language Impaired
- Deaf or Hearing Impaired
- Blind or Visually Limited
- Physically Handicapped and/or other Health Impairments, including
- Homebound, Hospitalized, and Pregnancy
- Learning Disabilities including the Perceptually Handicapped
- Emotionally Disturbed
- Socially Maladjusted
- Intellectually Gifted...
- Functionally Retarded

and is not being provided an appropriate educational program for his or her needs, or if your child has **any other need** or disability that is not being responded to in the regular classroom setting...

## ...Through Local School Districts

Then you should take steps to assist the local school district in meeting their responsibility.

As much as is practicable, students with a handicap shall be educated in classes attended primarily by pupils who are not handicapped. **But if your child requires special classes, facilities, and services, then these will be provided as much as the handicapping condition requires.**

## ...In a Normal Environment

The intent of the law is to provide a learning environment that is **as normal as possible.**

## ...With Necessary Support

- Special provisions include:
- Additional instructional materials
- Consulting teachers and specialists
- Resource Center Personnel
- Special Education Classes
- Home and Hospital Programs
- Special Schools if necessary
- Purchase of Special Education Services from a Private School or Facility

## ...Without Cost to Parents

The cost of these **necessary special education services** shall be provided by the State of Tennessee through the local school districts. This is done through the **Tennessee Foundation Program and Excess Cost Funds.**

**The law does not call for any funds, fees, or tuitions for special education services to be provided by the parent or guardian.**

## ...Steps to Take

These steps should be taken to provide your handicapped child with an appropriate educational program:

**(1) Screening-** Every school district is to have a screening program that includes all pupils. **Parent's permission is not required** for screening if the screening does not single out any individual.

**(2) Evaluation-** Testing is done by a team to determine the specific needs of the handicapped pupil. **Parent's written permission is required.**

**(3) Assessment-** A team of professional workers recommends a program to meet the needs of the handicapped pupil. **Assessment requires parent's permission.** Parents are to be involved and/or informed in detail of the assessment results and are to have access to the records.

**(4) Placement-** **Parents must give written permission** for their handicapped pupil to be provided with the recommended program. **A parent may request an independent evaluation or examination,** if they believe the current one in error. If the parent is unable to afford an independent evaluation or

(Cont. on back)

INSERVICE EDUCATION PROGRAM
FOR
PARTICIPANTS
ON PROGRAMS AND SERVICES
FOR PRESCHOOL HANDICAPPED CHILDREN

TSU-DOWNTOWN
NASHVILLE, TENNESSEE

November 20 - 21,1980

| | |
|---|---|
| 8:00 a.m. - 8:30 a.m. | Registration |
| 8:30 a.m. - 8 45 a.m. | Welcome and Agenda |
| 8:45 a.m. - 9:00 a.m. | Statement of Need - Betty Berry |
| 9:00 a.m. - 10:15 a.m. | Introduction to Child Check - Barbara Devaney<br>Regional Interventi<br>Program |
| 10:15 a.m. - 10:30 a.m | BREAK |
| 10:30 a.m. - 11:00 a.m. | Organization of the Community<br>Most/Least Effective Awareness Techniques |
| 11:00 a.m. 12:00(noon) | Case Study |
| 12:00 p.m. - 1:00 p.m. | LUNCH |
| 1:00 p.m. - 1: 15 p.m. | Volunteer Recruitment and Maintenance |
| 1:15 p.m. - 1:45 p.m. | Case Study |
| 1:45 p.m. - 2:00 p.m. | Parents Role in Monitoring Delivery of Services |
| 2:00 p.m. - 3: 00 p.m. | Legal Rights - Robert Tipps<br>Right to an Education Officer |
| 3:00 p.m. - 3:15 p.m. | BREAK |
| 3: 15 p.m. - 3: 45 p.m. | Data Collection Procedures |
| 3: 45 p.m. - 4:15 p.m. | General Discussion/ Wrap UP |
| 4 : 15 p.m. -4:30 p.m. | Distribute Materials |
| 5:15 p.m - 7:00 p.m. | Sharing Time<br>Ramada Inn |

CHILD FIND TRAINING

TENNESSEE DEPARTMENT OF EDUCATION

DIVISION FOR EDUCATION OF THE HANDICAPPED

January 8, 1981

January 8

| | |
|---|---|
| 8:30 - 9:00 | Introduction |
| 9:00 - 9:15 | Preparing a press kit |
| 9:15 - 10:00 | Radio publicity |
| 10:00 - 10:15 | Break |
| 10:15 - 10:45 | Television publicity |
| 10:45 - 11:15 | Newspaper publicity |
| 11:15 - 11:30 | Wrap up |

THE RIP EXPANSION PROJECT
2400 WHITE AVENUE
NASHVILLE, TENNESSEE 37204

Main Office
(615) 269-5671

Special Projects Office
(615) 741-6736

RECEIVED
MAR 11 1981

March 9, 1981

Dr. Tim Lynch, Executive Director
Sumner County Guidance Center
528 E. Main Street
Gallatin, TN 37066

Dear Tim:

This letter, signed by both of us in the spaces provided, will serve as a record of our agreement regarding the continued operation of a certified RIP expansion program sponsored by the Sumner County Guidance Center.

1.0 Sumner County Guidance Center

1.1 Agrees to provide one staff member, as an accepted participant in Training Cycle VIII scheduled to be conducted at the Regional Intervention Program facility, Nashville, Tennessee, from February 23, 1981, through April 17, 1981. Ms. will be expected to take part in all scheduled training program activities from 9:00 a.m. - 4:00 p.m. four days days per week.

1.2 Agrees to consult the Director of The RIP Expansion Project prior to the execution of any personnel action regarding termination and/or replacement and/or additions involving staff members engaged directly in the development and operation of the RIP expansion program.

1.3 Agrees that final decisions concerning certification of Ms. as a graduated of trainee of Training Cycle VIII will be made by the RIP Advisory Committee, Inc.

The official training and replication component of The RIP System. Sponsored by The Regional Intervention Program Advisory Committee, Inc. and Middle Tennessee Mental Health Institute, Children and Youth Community Services. Funded in part by The Bureau of Education for the Handicapped, Handicapped Children's Early Education Program (Outreach) Grant •OE G007803105.

upon recommendation of the Director of The RIP Expansion Project.

1.4 Agrees that upon certification of Ms. as a graduated trainee and upon her return to the Sumner County Guidance Center, she will devote no fewer than 30 hours per week (75% of scheduled work time) exclusively to activities related to the development and operation of the RIP expansion program.

1.5 Agrees to assume sole legal responsibility for all costs and liabilities associated with the development and operation of the RIP expansion program.

1.6 Acknowledges that the Director of The RIP Expansion Project, with the advice and consent of the RIP Advisory Committee, Inc., reserves the right to revoke certification of the RIP expansion program in the presence of irreconcilable differences regarding structure and operation of the program.

2.0 The RIP Expansion Project

2.1 Accepts Ms. as participant in Training Cycle VIII and accepts the Sumner County Guidance Center as a potential sponsor of a certified RIP expansion Program.

2.2 Agrees to provide a minimum 8 weeks training program experience at the Regional Intervention Program facility, Nashville, Tennessee, which includes a minimum of 17 direct contact hours per week with the parents and staff of RIP and The RIP Expansion Project.

2.3 Agrees to provide ongoing consultative and training support onsite and via telephone and mail following the graduated trainee's return to local community for a minimum of six calendar months. NOTE: Experience from 9/74 to date suggests that the ongoing support services are maintained far beyond six calendar months, decreasing in amount and intensity gradually as the local RIP expansion program matures.

2.4 Acts as authorized agent for the RIP Advisory Committee, Inc., in providing assistance in defraying travel, lodging and food expenses during the 8 week Nashville portion of training at a rate of up to $100.00 per week. Guidelines for training program reimbursement will be sent under separate cover.

2.5 Serves as authorized coordinator for the RIP Advisory Committee, Inc. Small Grants Program for certified RIP expansion programs. The 1979-80 edition of guidelines for the Small Grants Program will be sent under separate cover.

2.6 Acknowledges that the Director of the Sumner County Guidance Center, with the consent of his Board of Directors, reserves the right to cease operation of the RIP expansion program if and when such an action might become necessary.

The above items represent basic areas of agreement. There is, of course, a spirit as well as letter of this agreement that can best be described as mutual commitment to the development and operation of a sound RIP expansion program of superior quality. I think that we have done a good job of assessing the feasibility of establishing an expansion program under Sumner County Guidance Center sponsorship these past months. I look forward to a good working relationship.

Sincerely,

Matthew A. Timm, Ph.D.
Director

MAT/ml

Agreed:

Director
Sumner County Guidance Center

Date: 3-13-81

cc: (Approved version):

Ms.

Dr. Larry Thompson
Middle TN Mental Health Institute

Members and Participants
The RIP Advisory Committee, Inc.

October 1-3, 1980

# Fifth Annual RIP Expansion Conference

The Regional Intervention Program
The RIP Expansion Project
2400 White Avenue
Nashville, Tennessee

### Wednesday, October 1

9:00 Coffee and doughnuts

9:30 Longitudinal Follow Up of Behaviorally Disorded Children

Resources: Phillip Strain
Toni Ellis
Peggy Steele

10:45 Analysis of Cleveland Demographic Data

Resources: Staff, Early
Intervention Center
Cleveland, Ohio

12:00 LUNCH

1:30 Social Skills and Young Handicapped Children: Setting the Stage for Success

Resources: Thomas Powell, Social
Competency Intervention
Project
George Peabody College
of Vanderbilt Uni.

4:00 END

### Thursday, October 2

9:00 Coffee and doughnuts

9:30 Just Released: URE Expanding USEs

Resources: Barbara Fiechtl
Michelle Bourgeois
Parents and Staff of RIP
Expansion Projects

12:00 LUNCH

1:30 Measuring and Programming Language Generalization in the Classroom and Home

Resource: Steven Warren
Language Preschool
Project
University of Kansas

4:00 END

### Friday, October 3

9:00 Coffee and doughnuts

10:00 Families and Education: A Legal Prespective

Resources: Floyd Dennis
George Peabody College
of Vanderbilt Uni
Parents and Staff of
RIP Expansion
Project

12:30 END OF CONFERENCE